AMENDED IN ASSEMBLY APRIL 5, 1999

CALIFORNIA LEGISLATURE—1999–2000 REGULAR SESSION

ASSEMBLY BILL No. 525

Introduced by Assembly Members Kuehl and Thomson
(Coauthors: Assembly Members Aroner, Calderon, Firebaugh, Honda, Jackson, Keeley, Longville, Mazzoni, Romero, Shelley, and Wildman)
(Coauthors: Senators Figueroa, Hayden, and Solis)

February 18, 1999

An act to amend Sections 5914, 5917, and 5919 of the Corporations Code, to amend Sections 15438.5, 15459, 22774, 22778, and 22790 of the Government Code, to amend Sections 1345, 1363, 1367.10, and 129050 of, and to add Sections 1367.01, 1367.696, 1367.697, and 129021 to, the Health and Safety Code, to amend Sections 10123.12, 10140, 10291.5, 10604, and 10705 of, and to add Sections 10123.01, 10123.22, 10123.89, 10198.71, and 10702.2 to, the Insurance Code, and to amend Sections 14016.5, 14087.305, 14089, and 14165.6 of, and to add Sections 14016.71, 14016.8, and 14016.9 to, the Welfare and Institutions Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 525, as amended, Kuehl. Health benefits.

(1) Existing law requires a nonprofit corporation that is subject to the public benefit corporation law and is a health facility to give written notice to the Attorney General prior to entering into any agreement or transaction to dispose of its assets to a for-profit corporation or mutual benefit corporation

when a material amount of the assets of the public benefit corporation are involved in the agreement or transaction. Written notice is also required to transfer control, responsibility, or governance of a material amount of assets or operations.

This bill would require, instead, written notice under this provision from any foreign corporation, as defined, or public benefit corporation that owns or controls a health facility or facility that provides similar health care with regard to disposing of assets or transferring control, responsibility or governance to any other entity.

(2) Existing law authorizes the Attorney General to consent, give conditional consent, or not consent to any agreement or transaction under these provisions and requires the Attorney General to consider certain factors in making a determination.

This bill would revise those factors and would entitle the Attorney General to reimbursement for certain costs incurred in monitoring compliance with the terms of the consent or conditional consent.

(3) Existing law, the California Health Facilities Financing Authority Act, empowers the California Health Facilities Financing Authority to finance projects of health facilities that are operated by a city, county, city and county, a district hospital, or a private, nonprofit corporation or association. Existing law authorizes the authority to issue revenue bonds for this purpose.

This bill would prohibit the authority from issuing revenue bonds under these provisions to any health care facility that discriminates on the basis of race, color, religion, national origin, ancestry, sex, or sexual orientation.

(4) Existing law requires, as a condition of the issuance of revenue bonds to finance health facilities under these provisions that each borrower give reasonable assurance to the authority that the services of the health facility will be made available to all persons residing or employed in the area served by the facility.

This bill would add a requirement that (a) the borrower give reasonable assurance to the authority that the health facility does not discriminate on the basis of race, color,

religion, national origin, ancestry, sex, or sexual orientation and (b) certain borrowers shall provide directly, arrange for the provision of, or jointly provide in conjunction with another licensed facility, certain designated reproductive health services which the facility is licensed to provide.

(5) Existing law, the Public Employees' Medical and Hospital Care Act, provides health benefits plan coverage for public employees and annuitants meeting the eligibility requirements prescribed by the Board of Administration of the Public Employees' Retirement System.

This bill would prohibit the board from approving any health benefits plan contract with any carrier offering health benefit plans that discriminates on the basis of race, color, religion, national origin, ancestry, sex, or sexual orientation.

This bill would require the board to provide to employees and annuitants written notice, as provided under this bill, on how to access comprehensive reproductive health services, as defined. The bill would prohibit the board from approving a health benefits plan that contracts with a hospital or any other designated entity that excludes, limits, or restricts the provision of reproductive health services unless the plan also contracts with and makes available and accessible to its enrollees a similar provider or facility that does not exclude, limit, or restrict the service.

The bill would require the board to require any plan approved under these provisions to provide to all employees and annuitants written notice regarding access to comprehensive reproductive health services. The bill would require health benefits plans approved by the board and every contract entered into to provide health benefits to employees and annuitants that covers tubal ligations to ensure that voluntary tubal ligations are available at the time of labor and delivery.

(6) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Commissioner of Corporations. The willful violation of the provisions governing health care service plans is a crime.

Existing law requires each health care service plan to use a disclosure form or materials containing designated

information regarding the benefits, services, and terms of the plan contract as required by the commissioner. The disclosure form is required to include the principal benefits and coverage of the plan, including coverage for acute care and subacute care, and the exceptions, reductions, and limitations that apply to the plan.

This bill would revise these disclosure requirements to require disclosure of (a) comprehensive reproductive health services, (b) the hospitals, clinics, ambulatory surgical centers, independent physician associations, medical groups, pharmacies, and other principal primary, ancillary, or specialty health care facilities available in the health plan network, (c) exceptions, reductions, and limitations on reproductive health services, and (d) hospitals and designated entities that do not provide comprehensive reproductive health services.

(7) Existing law requires additional disclosure by health care service plans that describes how participation in the plan may affect the choice of physician, hospital, or other health care providers, the basic method of reimbursement, including the scope and general methods of payment made to its contracting providers of health care services, and whether financial bonuses or any other incentives are used.

This bill would revise this disclosure requirement to include disclosures related to a person's ability to access comprehensive reproductive health services.

(8) Existing law prohibits a health care service plan from refusing to enter into any contract or canceling or declining to renew or reinstate any contract because of the race, color, national origin, ancestry, religion, marital status, sexual orientation, or age of any contracting party, prospective contracting party, or person reasonably expected to benefit from that contract as a subscriber, enrollee, member, or otherwise. Existing law also prohibits discrimination with regard to the modification of any contract and the benefits or coverage of any contract.

This bill would prohibit a health care service plan that issues, provides, or administers any individual or group health care service plan from refusing to cover, or refusing to continue to cover, or limiting the amount, extent, or kind of

coverage available to an individual, or charging a different rate for the same coverage because of race, color, religion, national origin, ancestry, sex, or sexual orientation.

(9) Existing law requires every health care service plan to meet certain requirements, including providing to subscribers and enrollees basic health care services, as defined.

This bill would require, on and after July 1, 2000, certain health care service plans that contract with a hospital or designated entities that exclude, limit, or restrict the provision of reproductive health services to contract with and make available and accessible to its enrollees a similar provider or facility that does not exclude, limit, or restrict the service.

The bill would require a health care service plan to provide to all enrollees certain written notice on how to access comprehensive reproductive health services.

The bill would require that a health care service plan contract issued, amended, or renewed on or after July 1, 2000, that covers tubal ligations ensure that voluntary tubal ligations are available at the time of labor and delivery, as provided under the bill.

This bill would define ''comprehensive reproductive health services'' for purposes of the bill.

By changing the requirements of health care service plans, this bill would change the definition of a crime, thereby imposing a state-mandated local program.

(10) Existing law, the California Health Facility Construction Loan Insurance Law, administered by the Office of Statewide Health Planning and Development, provides for an insurance program for public and nonprofit health facility construction, improvement, and expansion loans.

This bill would prohibit the office from approving an application or providing loan insurance under these provisions to any borrower that discriminates on the basis of race, color, religion, national origin, ancestry, sex, or sexual orientation. The bill would require each borrower to give reasonable assurance to the office that the borrower does not discriminate as provided under the bill. The bill would require

certain borrowers to provide designated reproductive health services that it is licensed to provide.

(11) Existing law provides for the regulation of insurance, including disability insurers, insurers issuing policies of disability insurance, and self-insured employee welfare benefit plans that cover hospital, medical, or surgical expenses. These provisions are administered by the Commissioner of Insurance.

This bill would set forth requirements of these insurers and plans similar to those required under the bill for health care service plans with regard to (a) disclosing information about the insureds or enrollees ability to access comprehensive reproductive health services, (b) making reproductive health services available and accessible, (c) providing written notice about how to access comprehensive reproductive health services, and (d) making voluntary tubal ligations available at the time of labor and delivery.

(12) Existing law prohibits any admitted insurer, licensed to issue any policy of insurance, including disability insurance, from failing or refusing to accept an application for, or issuing a policy to an applicant for, insurance, or canceling the insurance, under conditions less favorable to the insured than in other comparable cases, except for reasons applicable alike to persons of every marital status, sex, race, color, religion, national origin, or ancestry and prohibits sex, race, color, religion, national origin, or ancestry of itself from constituting a condition or risk for which a higher rate, premium, or charge may be required of the insured for insurance.

This bill would prohibit an insurer licensed to issue disability insurance policies for, and a self-insured employee welfare benefit plan that provides, hospital, medical, and surgical expenses from offering or providing different terms, conditions, or benefits, or placing a limitation on coverage under the insurance on the basis of a person’s race, color, religion, national origin, ancestry, sex, or sexual orientation.

(13) Existing law prohibits the Insurance Commissioner from approving any disability policy for insurance that does not conform to specified requirements.

This bill would prohibit the commissioner from approving a disability policy of insurance that discriminates on the basis

of race, color, religion, national origin, ancestry, sex, or sexual orientation.

(14) Existing law provides for additional disclosure requirements with regard to disability insurers that requires the insurer to use a disclosure form that includes, among other things, the principal benefits and coverage of the plan and the exceptions, reductions, and limitations that apply to the plan.

This bill would revise these disclosure requirements to require certain disability insurers to disclose comprehensive reproductive health services and exceptions, reductions, and limitations on comprehensive reproductive health services.

(15) Existing law provides a comprehensive program for providing health insurance to small employer groups which sets forth requirements of all carriers writing, issuing, or administering health benefit plans that cover employees of small employers. Existing law requires these carriers to prepare a brochure and detailed evidence of coverage as specified.

This bill would prohibit these carriers from offering or providing different terms, conditions, or benefits, or placing a limitation on coverage under health benefit plans on the basis of an employee's race, color, religion, national origin, ancestry, sex, or sexual orientation. This bill would require the brochure and evidence of coverage to include information related to comprehensive reproductive health services.

(16) Existing law provides for the Medi-Cal program which is administered by the State Department of Health Services, pursuant to which medical benefits are provided to public assistance recipients and certain other low-income persons. Under existing law, Medi-Cal services may be provided to a beneficiary or eligible applicant by an individual provider, or through a prepaid managed health care plan, pilot project, or fee-for-service case management provider.

This bill would require, on or after July 1, 2000, that (a) Medi-Cal managed health care plan contracts with hospitals and designated other entities that exclude, limit, or restrict the provision of reproductive health services, contract with and make available and accessible to enrollees a similar provider or facility that does not exclude, limit, or restrict the service, (b) Medi-Cal managed health care plans make

voluntary tubal ligations available as provided under the bill, and (c) Medi-Cal managed health care plans provide specified written notice about how to access comprehensive reproductive health services. The bill would define ‘‘managed health care plans’’ for purposes of these provisions.

(17) Existing law requires that the county ensure that each Medi-Cal beneficiary or eligible applicant be provided with information as to health care and managed care options, including certain provider information.

This bill would require that certain information be provided in the manner specified in the bill to each Medi-Cal applicant or beneficiary related to the principal benefits and coverage of the plan, including comprehensive reproductive health services, hospitals and other entities available in the health plan network, the exceptions, reductions, and limitations, that apply to the plan, including those related to comprehensive reproductive health services, and the hospitals and other entities that do not provide comprehensive reproductive health services. The bill would require a county organized health system to provide the same information to Medi-Cal applicants and beneficiaries and would define ‘‘county organized health systems’’ for this purpose. Because the bill would impose new duties upon county officials, the bill would impose a state-mandated local program.

(18) Existing law declares the purpose of the Waxman-Duffy Prepaid Health Plan Act is to afford persons eligible to receive Medi-Cal benefits the opportunity to enroll as regular subscribers in prepaid health plans, without reference to the race, sex, age, religion, creed, color, national origin, or ancestry of any eligible person.

This bill would prohibit all managed health care plans from discriminating against Medi-Cal beneficiaries and enrollees as provided in the bill.

(19) Existing law establishes the California Medical Assistance Commission to contract with health care delivery systems for provision of health care services to recipients under the Medi-Cal program.

This bill would require that all contracts negotiated by the commission prohibit discrimination against Medi-Cal beneficiaries and enrollees in the terms, conditions, or

benefits and prohibit any limitation on coverage or the provision of services on the basis of race, color, religion, national origin, ancestry, sex, or sexual orientation.

(20) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement, including the creation of a State Mandates Claims Fund to pay the costs of mandates that do not exceed $1,000,000 statewide and other procedures for claims whose statewide costs exceed $1,000,000.

This bill would provide that with regard to certain mandates no reimbursement is required by this act for a specified reason.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 5914 of the Corporations Code is amended to read:

5914. (a) Any foreign corporation, as defined in Section 5053, or public benefit corporation that owns or controls a health facility, as defined in Section 1250 of the Health and Safety Code, or owns or controls a facility that provides similar health care, shall be required to provide written notice to, and to obtain the written consent of, the Attorney General prior to entering into any agreement or transaction to do either of the following:

(1) Sell, transfer, lease, exchange, option, convey, or otherwise dispose of, its assets to any other entity when a material amount of the assets of the foreign corporation or public benefit corporation are involved in the agreement or transaction.

(2) Transfer control, responsibility, or governance of a material amount of the assets or operations of the foreign corporation or public benefit corporation to any other entity.

(b) The notice to the Attorney General provided for in this section shall include and contain the information the Attorney General determines is required.

(c) This article shall not apply to a public benefit corporation if the agreement or transaction is in the usual and regular course of its activities or if the Attorney General has given the corporation a written waiver of this article as to the proposed agreement or transaction.

SEC. 2. Section 5917 of the Corporations Code is amended to read:

5917. The Attorney General shall have discretion to consent to, give conditional consent to, or not consent to any ~~such~~ agreement or transaction described in subdivision (a) of Section 5914. In making the determination, the Attorney General shall consider any factors that the Attorney General deems relevant, including, but not limited to, whether any of the following apply:

(a) The terms and conditions of the agreement or transaction are fair and reasonable to the nonprofit public benefit corporation.

(b) The agreement or transaction will result in inurement to any private person or entity.

(c) Any agreement or transaction that is subject to this article is at fair market value. In this regard, ‘‘fair market value’’ means the most likely price that the assets being sold would bring in a competitive and open market under all conditions requisite to a fair sale, the buyer and seller, each acting prudently, knowledgeably and in their own best interest, and a reasonable time being allowed for exposure in the open market.

(d) The market value has been manipulated by the actions of the parties in a manner that causes the value of the assets to decrease.

(e) The proposed use of the proceeds from the agreement or transaction is consistent with the charitable

trust on which the assets are held by the health facility or by the affiliated nonprofit health system, which charitable trust shall be determined by the review of, among other things, the original articles of corporation and any amendments thereto, any express trusts, donative, or other legal instruments, and by review of the history of charitable operations.

(f) The agreement or transaction involves or constitutes any breach of trust.

(g) The Attorney General has been provided, pursuant to Section 5250, with sufficient information and data by the nonprofit public benefit corporation to evaluate adequately the agreement or transaction or the effects thereof on the public.

(h) The agreement or transaction may create or perpetuate a significant effect on the availability or accessibility of health care services to the affected community. In this review process, the Attorney General shall separately consider the access and availability to the affected community of reproductive health services, emergency or urgent care services, and indigent care *services*.

(i) The proposed agreement or transaction is in the public interest.

SEC. 3. Section 5919 of the Corporations Code is amended to read:

5919. (a) Within the time periods designated in Section 5915 and relating to those factors specified in Section 5917, the Attorney General may do the following:

(1) Contract with, consult, and receive advice from any state agency on those terms and conditions that the Attorney General deems appropriate.

(2) In his or her sole discretion, contract with experts or consultants to assist in reviewing the proposed agreement or transaction.

(b) Contract costs shall not exceed an amount that is reasonable and necessary to conduct the review and evaluation. Any contract entered into under this section shall be on a noncompetitive bid basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part

2 of Division 2 of the Public Contract Code. The nonprofit public benefit corporation, upon request, shall pay the Attorney General promptly for all contract costs.

(c) The Attorney General shall be entitled to reimbursement from the foreign corporation or nonprofit public benefit corporation for all actual, reasonable, direct costs incurred in reviewing, evaluating, and making the determination referred to in this article, including administrative costs. The foreign corporation or nonprofit public benefit corporation shall promptly pay the Attorney General, upon request, for all ~~such~~ *of these* costs.

(d) If the Attorney General consents or conditionally consents to an agreement or transaction described in subdivision (a) of Section 5914, the Attorney General shall be entitled to reimbursement for all actual, reasonable, and direct costs incurred in monitoring compliance with the terms of the consent or conditional consent, including administrative costs from the entity that assumes any of the charitable trust obligations of the transferring entity.

SEC. 4. Section 15438.5 of the Government Code is amended to read:

15438.5. (a) It is the intent of the Legislature in enacting this part to provide financing only, and, except as provided in subdivisions (b), (c), and (d), only to health facilities which can demonstrate the financial feasibility of their projects without regard to the more favorable interest rates anticipated through the issuance of revenue bonds under this part. It is further the intent of the Legislature that all or part of any savings experienced by a participating health institution, as a result of that tax-exempt revenue bond funding, be passed on to the consuming public through lower charges or containment of the rate of increase in hospital rates. It is not the intent of the Legislature in enacting this part to encourage unneeded health facility construction. Further, it is not the intent of the Legislature to authorize the authority to control or participate in the operation of

hospitals, except where default occurs or appears likely to occur.

(b) When determining the financial feasibility of projects for county health facilities, the authority shall consider the more favorable interest rates reasonably anticipated through the issuance of revenue bonds under this part. It is the intent of the Legislature that the authority attempt in whatever ways possible to assist counties to arrange projects which will meet the financial feasibility standards developed under this part.

(c) The authority may issue revenue bonds pursuant to this part to finance the development of a multilevel facility, or any portion of a multilevel facility, including the portion licensed as a residential facility for the elderly, if the skilled nursing facility, intermediate care facility, or general acute care hospital is operated or provided by an eligible participating health institution.

(d) The authority may issue revenue bonds pursuant to this part, if the bonds rank in either of the two highest rating categories established by a nationally recognized bond rating organization, to finance working capital for a participating health institution provided or operated by a city, city and county, county, or district hospital authorized by the laws of this state to provide or operate a health facility and which, pursuant to this part, undertakes financing or refinancing as provided in this part.

(e) The financing or refinancing of projects or working capital for cities, cities and counties, counties, or hospital districts may be provided pursuant to this part by means other than revenue bonds, at the discretion of the authority, including, without limitation, through certificates of participation, or other interests, in bonds, loans, leases, installment sales or other agreements of the cities, city and county, counties or hospital districts. In this connection, the authority may do all things and execute and deliver all documents and instruments as may be necessary or desirable in connection with issuance of the certificates of participation or other means of financing or refinancing.

(f) Any self-insurance pooling program entered into by participating health institutions which are cities, counties, cities and counties, or hospital districts which is funded or financed in whole or in part with proceeds of the sale of revenue bonds or certificates of participation pursuant to this part shall not be subject to regulation of any kind under the Insurance Code or otherwise as insurance, but only any conditions and restrictions as may be imposed by the authority.

(g) If a health facility seeking financing for a project pursuant to this part does not meet the guidelines established by the authority with respect to bond rating, the authority may nonetheless give special consideration, on a case-by-case basis, to financing the project if the health facility demonstrates to the satisfaction of the authority the financial feasibility of the project, and the performance of significant community service. For the purposes of this part, a health facility which performs a significant community service is one that contracts with Medi-Cal or that can demonstrate, with the burden of proof being on the health facility, that it has fulfilled at least two of the following criteria:

(1) On or before January 1, 1991, has established, and agrees to maintain, a 24-hour basic emergency medical service open to the public with a physician and surgeon on duty, or is a children's hospital as defined in Section 14087.21 of the Welfare and Institutions Code, which jointly provides basic or comprehensive emergency services in conjunction with another licensed hospital. This criterion shall not be utilized in a circumstance where a small and rural hospital, as defined in Section 442.2 of the Health and Safety Code, has not established a 24-hour basic emergency medical service with a physician and surgeon on duty; or will operate a designated trauma center on a continuing basis during the life of the revenue bonds issued by the authority.

(2) Has adopted, and agrees to maintain on a continuing basis during the life of the revenue bonds issued by the authority, a policy, approved and recorded by the facility's board of directors, of treating all patients

without regard to ability to pay, including, but not limited to, emergency room walk-in patients.

(3) Has provided and agrees to provide care, on a continuing basis during the life of the revenue bonds issued by the authority, to Medi-Cal and uninsured patients in an amount not less than 5 percent of the facility's adjusted inpatient days as reported on an annual basis to the Office of Statewide Health Planning and Development.

(4) Has budgeted at least 5 percent of its net operating income to meeting the medical needs of uninsured patients and to providing other services, including, but not limited to, community education, primary care outreach in ambulatory settings, and unmet nonmedical needs, such as food, shelter, clothing, or transportation for vulnerable populations in the community, and agrees to continue that policy during the life of the revenue bonds issued by the authority.

On or before January 1, 1992, the authority shall report to the Legislature regarding the implementation of this subdivision. The report shall provide information on the number of applications for financing sought under this subdivision, the number of applications approved and denied under this subdivision, and a brief summary of the reason for any denial of an application submitted under this subdivision.

(h) Enforcement of the conditions under which the authority issues bonds pursuant to this section shall be governed by the enforcement conditions under Section 15459.4.

(i) Notwithstanding any other provision of law, the authority shall not issue revenue bonds pursuant to this part to any health care facility that discriminates on the basis of race, color, religion, national origin, ancestry, sex, or sexual orientation.

SEC. 5. Section 15459 of the Government Code is amended to read:

15459. (a) As a condition of the issuance of revenue bonds, whether by the authority or any local agency, to finance the construction, expansion, remodeling,

renovation, furnishing, or equipping of a health facility or the acquisition of a health facility, the following shall apply:

(1) Each borrower shall give reasonable assurance to the authority that the services of the health facility will be made available to all persons residing or employed in the area served by the facility.

(2) Each borrower, notwithstanding any other provision of law, shall give reasonable assurance to the authority that the health facility does not discriminate on the basis of race, color, religion, national origin, ancestry, sex, or sexual orientation.

(3) Each borrower, notwithstanding any other provision of law, that is a general acute care hospital, special health care facility that delivers general health inpatient or outpatient care, as defined in Section 15432, shall provide directly, arrange for the provision of, or jointly provide in conjunction with another licensed facility, those reproductive health services, as defined in subdivision (c) of Section 1345, which the entity is licensed to provide. Nothing in this paragraph shall be construed to require a borrower to furnish services for which it is not licensed to provide.

(b) For the purposes of this section and Sections 15459.1, 15459.2, 15459.3, and 15459.4, all of the following definitions apply:

(1) ‘‘Borrower’’ means each local agency or nonprofit corporation or association which operates or provides the health facility and receives the benefit of the issuance of revenue bonds.

(2) ‘‘Local agency’’ means any public district, public corporation, authority, agency, board, commission, county, city and county, city, school district, or any other public entity.

(3) ‘‘Revenue bond’’ means any bonds, warrants, notes, lease, or installment sale obligations evidenced by certificates of participation, or other evidence of indebtedness issued by the authority or by a local agency payable from funds other than the proceeds of ad valorem taxes or the proceeds of assessments levied without

limitation as to rate or amount by the local agency upon property in the local agency.

SEC. 6. Section 22774 of the Government Code is amended to read:

22774. (a) The board shall, in accordance with this part, approve health benefits plans and may contract with carriers offering health benefits plans.

(b) Notwithstanding any other provision of law, the board shall not approve any health benefits plan or contract with any carrier offering health benefit plans that discriminates on the basis of race, color, religion, national origin, ancestry, sex, or sexual orientation.

(c) Irrespective of the provisions of Sections 1090 and 1091, the board member who is an officer of a life insurer may participate in all board activities in administering the provisions of this part, except that he or she shall not vote on the question of whether a contract should be entered into or approval should be given concerning any plan.

SEC. 7. Section 22778 of the Government Code is amended to read:

22778. (a) The board shall make available to employees and annuitants eligible to enroll in any health benefit plan pursuant to this part ~~such~~ information, in ~~such form as~~ *the form that* it may deem satisfactory, as will enable the employees or annuitants to exercise an informed choice among the various types of health benefits plans which have been contracted for or approved. Each employee or annuitant enrolled in a health benefits plan shall be issued an appropriate document setting forth or summarizing the services or benefits to which the employee or annuitant or family members are entitled to thereunder, the procedure for obtaining benefits, and the principal provisions of the plan affecting the employee, annuitant, or family members.

(b) Notwithstanding subdivision (a), and Section 22779, the board shall provide to employees and annuitants written notice in readily understood language and in a clearly organized format on how to access

comprehensive reproductive health services, as defined in subdivision (c) of Section 1345 of the Health and Safety Code. This written notice shall be provided, commencing March 1, 2000, upon the employee's or annuitant's enrollment, and annually thereafter. In addition, the plan shall provide this written notice to all pregnant enrollees during the course of prenatal care if the plan received notice, whether by receipt of a claim, a request for preauthorization for pregnancy-related services, or other actual notice that the enrollee is pregnant.

(c) The board shall compile and provide data regarding age, sex, family composition, and geographical distribution of employees and annuitants and make continuing study of the operation of this part, including, but not necessarily limited to, surveys and reports on plans, medical and hospital benefits, the standard of care available to employees and annuitants, and the experience of plans receiving contributions under this part with respect to ~~such matters~~ *matters such* as gross and net cost, administrative cost, benefits, utilization of benefits, and the portion of actual personal expenditure of employees and annuitants for health care which is being met by prepaid benefits; provided, however, that this section shall not be construed to require any plan to provide accounting data or statistical data which is not acquired in the normal operation of the plan.

(d) The board shall, with the advice of and in consultation and cooperation with, professional medical organizations and individuals or organizations having special skills or experience in the organization and provision of health care services on a prepaid basis, study methods of evaluating and improving the quality and cost of medical and hospital care provided under this part.

SEC. 8. Section 22790 of the Government Code is amended to read:

22790. (a) The board may contract with carriers for health benefits plans for employees and annuitants and major medical plans or approve health benefit plans offered by employee organizations, provided that the carriers have operated successfully in the prepaid

hospital and medical care field prior to the contracting for or approval thereof. The plans may include hospital benefits, surgical benefits, in-hospital medical benefits, outpatient benefits, and obstetrical benefits, and benefits offered by a bona fide church, sect, denomination or organization whose principles include healing entirely by prayer or spiritual means. The board shall contract with a sufficient number of carriers and plans that provide chiropractic services so that every employee and annuitant shall have a reasonable opportunity to enroll in a plan that provides chiropractic services without prior referral by a physician. The board may contract with health maintenance organizations approved under Title XIII of the federal Public Health Services Act (42 U.S.C. Sec. 201 et seq.).

(b) Notwithstanding any other provision of this part, the board also may contract with health plans offering unique or specialized health services.

(c) The board shall approve any employee association health benefits plan which was approved by the board in the 1987–88 contract year or any year prior to that date, provided the plan continues to meet the minimum standards prescribed by the board.

(d) The board shall provide and administer any health benefits or other coverage extended at county cost under Section 77208, upon receipt of a resolution from a county board of supervisors electing to come under the administrative provisions of this part for the coverage specified in the resolution.

(e) The board shall not approve a health benefits plan that contracts with a hospital, clinic, medical group, independent physician association, ambulatory surgical center, pharmacy, or other primary, ancillary, or specialty health care facility or provider that excludes, limits, or restricts the provision of any of the reproductive health services enumerated in subdivision (c) of Section 1345 of the Health and Safety Code, unless the plan also contracts with and makes available and accessible to its enrollees a similar provider or facility that does not exclude, limit, or restrict the service. These services shall

be available and accessible within reasonable proximity to the residence or place of business of the employees and annuitants, except when no such facility exists, in which case, the insurer shall provide transportation. Nothing in this section shall be construed to permit any plan to apply a higher deductible or copayment for services provided under this section.

(f) The board shall require that any health benefits plan approved under this section shall provide to all employees and annuitants written notice in readily understood language and in a clearly organized format on how to access comprehensive reproductive health services, as defined in subdivision (c) of Section 1345 of the Health and Safety Code. This written notice shall be provided, commencing March 1, 2000, upon the employee's or annuitant's enrollment, and annually thereafter. In addition, the plan shall provide this written notice to all pregnant employees or annuitants during the course of prenatal care if the plan received notice, whether by receipt of a claim, a request for preauthorization for pregnancy-related services, or other actual notice that the employee or annuitant is pregnant.

(g) Every health benefits plan approved by the board and every contract entered into to provide health benefits to employees and annuitants that covers tubal ligations shall ensure that voluntary tubal ligations are available at the time of labor and delivery. These services shall be available and accessible within reasonable proximity to the residence or place of business of the enrollee, except when no such facility exists, in which case, the insurer shall provide transportation. Nothing in this subdivision shall be construed to permit any carriers to apply a higher deductible or copayment for services provided under this section.

SEC. 9. Section 1345 of the Health and Safety Code is amended to read:

1345. As used in this chapter:

(a) ''Advertisement'' means any written or printed communication or any communication by means of recorded telephone messages or by radio, television, or

similar communications media, published in connection with the offer or sale of plan contracts.

(b) ''Basic health care services'' means all of the following:

(1) Physician services, including consultation and referral.

(2) Hospital inpatient services and ambulatory care services.

(3) Diagnostic laboratory and diagnostic and therapeutic radiologic services.

(4) Home health services.

(5) Preventive health services.

(6) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage. ''Basic health care services'' includes ambulance and ambulance transport services provided through the ''911'' emergency response system.

(c) ''Comprehensive reproductive health services'' means preconception counseling and care, pregnancy-related services, fertility management, abortion, emergency contraception, voluntary sterilization, including voluntary tubal ligation at the time of delivery, family planning, including all services and supplies approved by the federal Food and Drug Administration, both prescription and nonprescription, diagnosis and treatment of sexually transmitted diseases, and diagnosis of breast and gynecological cancers.

(d) ''Enrollee'' means a person who is enrolled in a plan and who is a recipient of services from the plan.

(e) ''Evidence of coverage'' means any certificate, agreement, contract, brochure, or letter of entitlement issued to a subscriber or enrollee setting forth the coverage to which the subscriber or enrollee is entitled.

(f) ''Group contract'' means a contract which by its terms limits the eligibility of subscribers and enrollees to a specified group.

(g) ''Health care service plan'' or ''specialized health care service plan'' means either of the following:

(1) Any person who undertakes to arrange for the provision of health care services to subscribers or

enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.

(2) Any person, whether located within or outside of this state, who solicits or contracts with a subscriber or enrollee in this state to pay for or reimburse any part of the cost of, or who undertakes to arrange or arranges for, the provision of health care services that are to be provided wholly or in part in a foreign country in return for a prepaid or periodic charge paid by or on behalf of the subscriber or enrollee.

(h) ''License'' means, and ''licensed'' refers to, a license as a plan pursuant to Section 1353.

(i) ''Out-of-area coverage,'' for purposes of paragraph (6) of subdivision (b), means coverage while an enrollee is anywhere outside the service area of the plan, and shall also include coverage for urgently needed services to prevent serious deterioration of an enrollee's health resulting from unforeseen illness or injury for which treatment cannot be delayed until the enrollee returns to the plan's service area.

(j) ''Provider'' means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

(k) ''Person'' means any person, individual, firm, association, organization, partnership, business trust, foundation, labor organization, corporation, limited liability company, public agency, or political subdivision of the state.

(*l*) ''Service area'' means a geographical area designated by the plan within which a plan shall provide health care services.

(m) ''Solicitation'' means any presentation or advertising conducted by, or on behalf of, a plan, where information regarding the plan, or services offered and charges therefor, is disseminated for the purpose of inducing persons to subscribe to, or enroll in, the plan.

(n) ''Solicitor'' means any person who engages in the acts defined in subdivision (m) of this section.

(o) ‘‘Solicitor firm’’ means any person, other than a plan, who through one or more solicitors engages in the acts defined in subdivision (m) of this section.

(p) ‘‘Specialized health care service plan contract’’ means a contract for health care services in a single specialized area of health care, including dental care, for subscribers or enrollees, or which pays for or which reimburses any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.

(q) ‘‘Subscriber’’ means the person who is responsible for payment to a plan or whose employment or other status, except for family dependency, is the basis for eligibility for membership in the plan.

(r) Unless the context indicates otherwise, ‘‘plan’’ refers to health care service plans and specialized health care service plans.

(s) ‘‘Plan contract’’ means a contract between a plan and its subscribers or enrollees or a person contracting on their behalf pursuant to which health care services, including basic health care services, are furnished; and unless the context otherwise indicates it includes specialized health care service plan contracts; and unless the context otherwise indicates it includes group contracts.

(t) All references in this chapter to financial statements, assets, liabilities, and other accounting items mean those financial statements and accounting items prepared or determined in accordance with generally accepted accounting principles, and fairly presenting the matters which they purport to present, subject to any specific requirement imposed by this chapter or by the commissioner.

SEC. 10. Section 1363 of the Health and Safety Code is amended to read:

1363. (a) The commissioner shall require the use by each plan of disclosure forms or materials containing information regarding the benefits, services, and terms of the plan contract as the commissioner may require, so as to afford the public, subscribers, and enrollees with a full

and fair disclosure of the provisions of the plan in readily understood language and in a clearly organized manner. The commissioner may require that the materials be presented in a reasonably uniform manner so as to facilitate comparisons between plan contracts of the same or other types of plans. Nothing contained in this chapter shall preclude the commissioner from permitting the disclosure form to be included with the evidence of coverage or plan contract.

The disclosure form shall provide for at least the following information, in concise and specific terms, relative to the plan, together with additional information as may be required by the commissioner, in connection with the plan or plan contract:

(1) The principal benefits and coverage of the plan, including coverage for acute care, subacute care, and comprehensive reproductive health services, as defined in subdivision (c) of Section 1345, and the hospitals, clinics, ambulatory surgical centers, independent physician associations, medical groups, pharmacies, and other principal primary, ancillary, or specialty health care facilities available in the health plan network.

(2) The exceptions, reductions, and limitations that apply to the plan, including exceptions, reductions, and limitations on reproductive health services and the hospitals, ambulatory surgical centers, pharmacies, independent physician associations, medical groups and other primary, ancillary, or specialty health care facilities that do not provide comprehensive reproductive health services, as defined in subdivision (c) of Section 1345.

(3) The full premium cost of the plan.

(4) Any copayment, coinsurance, or deductible requirements that may be incurred by the member or the member's family in obtaining coverage under the plan.

(5) The terms under which the plan may be renewed by the plan member, including any reservation by the plan of any right to change premiums.

(6) A statement that the disclosure form is a summary only, and that the plan contract itself should be consulted to determine governing contractual provisions. The first

page of the disclosure form shall contain a notice that conforms with all of the following conditions:

(A) (i) States that the evidence of coverage discloses the terms and conditions of coverage.

(ii) States, with respect to individual plan contracts, small group plan contracts, and any other group plan contracts for which health care services are not negotiated, that the applicant has a right to view the evidence of coverage prior to enrollment, and, if the evidence of coverage is not combined with the disclosure form, the notice shall specify where the evidence of coverage can be obtained prior to enrollment.

(B) Includes a statement that the disclosure and the evidence of coverage should be read completely and carefully and that individuals with special health care needs, including reproductive health care needs, should read carefully those sections that apply to them.

(C) Includes the plan's telephone number or numbers that may be used by an applicant to receive additional information about the benefits of the plan or a statement where the telephone number or numbers are located in the disclosure form.

(D) For individual contracts, and small group plan contracts as defined in Article 3.1 (commencing with Section 1357), the disclosure form shall state where the health plan benefits and coverage matrix is located.

(E) Is printed in type no smaller than that used for the remainder of the disclosure form and is displayed prominently on the page.

(7) A statement as to when benefits shall cease in the event of nonpayment of the prepaid or periodic charge and the effect of nonpayment upon an enrollee who is hospitalized or undergoing treatment for an ongoing condition.

(8) To the extent that the plan permits a free choice of provider to its subscribers and enrollees, the statement shall disclose the nature and extent of choice permitted and the financial liability which is, or may be, incurred by the subscriber, enrollee, or a third party by reason of the exercise of that choice.

(9) A summary of the provisions required by subdivision (g) of Section 1373, if applicable.

(10) If the plan utilizes arbitration to settle disputes, a statement of that fact.

(11) A summary of, and a notice of the availability of, the process the plan uses to authorize or deny health care services under the benefits provided by the plan, pursuant to Section 1363.5.

(12) A description of any limitations on the patient's choice of primary care or specialty care physician based on service area and limitations on the patient's choice of acute care hospital care, subacute or transitional inpatient care, or skilled nursing facility.

(13) General authorization requirements for referral by a primary care physician to a specialty care physician.

(14) Conditions and procedures for disenrollment.

(15) A description as to how an enrollee may request continuity of care as required by Section 1373.96.

(b) (1) As of July 1, 1999, the commissioner shall require each plan offering a contract to an individual or small group to provide with the disclosure form for individual and small group plan contracts a uniform health plan benefits and coverage matrix containing the plan's major provisions in order to facilitate comparisons between plan contracts. The uniform matrix shall include the following category descriptions together with the corresponding copayments and limitations in the following sequence:

(A) Deductibles.

(B) Lifetime maximums.

(C) Professional services.

(D) Outpatient services.

(E) Hospitalization services.

(F) Emergency health coverage.

(G) Ambulance services.

(H) Prescription drug coverage.

(I) Durable medical equipment.

(J) Mental health services.

(K) Chemical dependency services.

(L) Home health services.

(M) Comprehensive reproductive health services, as defined in subdivision (c) of Section 1345.

(N) Other.

(2) The following statement shall be placed at the top of the matrix in all capital letters in at least 10-point boldface type:

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

(c) Nothing in this section shall prevent a plan from using appropriate footnotes or disclaimers to reasonably and fairly describe coverage arrangements in order to clarify any part of the matrix that may be unclear.

(d) All plans, solicitors, and representatives of a plan shall, when presenting any plan contract for examination or sale to an individual prospective plan member, provide the individual with a properly completed disclosure form, as prescribed by the commissioner pursuant to this section for each plan so examined or sold.

(e) In the case of group contracts, the completed disclosure form and evidence of coverage shall be presented to the contractholder upon delivery of the completed health care service plan agreement.

(f) Group contractholders shall disseminate copies of the completed disclosure form to all persons eligible to be a subscriber under the group contract at the time those persons are offered the plan. Where the individual group members are offered a choice of plans, separate disclosure forms shall be supplied for each plan available. Each group contractholder shall also disseminate or cause to be disseminated copies of the evidence of coverage to all applicants, upon request, prior to enrollment and to all subscribers enrolled under the group contract.

(g) In the case of conflicts between the group contract and the evidence of coverage, the provisions of the

evidence of coverage shall be binding upon the plan notwithstanding any provisions in the group contract which may be less favorable to subscribers or enrollees.

(h) In addition to the other disclosures required by this section, every health care service plan and any agent or employee of the plan shall, when presenting a plan for examination or sale to any individual purchaser or the representative of a group consisting of 25 or fewer individuals, disclose in writing the ratio of premium costs to health services paid for plan contracts with individuals and with groups of the same or similar size for the plan's preceding fiscal year. A plan may report that information by geographic area, provided the plan identifies the geographic area and reports information applicable to that geographic area.

(i) Subdivision (b) shall not apply to any coverage provided by a plan for the Medi-Cal program or the Medicare program pursuant to Title XVIII and Title XIX of the Social Security Act.

(j) This section shall become operative July 1, 1999.

SEC. 11. Section 1367.01 is added to the Health and Safety Code, to read:

1367.01. Notwithstanding any other provision of law, no plan issuing, providing, or administering any individual or group health care service plan shall refuse to cover, or refuse to continue to cover, or limit the amount, extent, or kind of coverage available to an individual, or charge a different rate for the same coverage because of race, color, religion, national origin, ancestry, sex, or sexual orientation.

SEC. 12. Section 1367.10 of the Health and Safety Code is amended to read:

1367.10. (a) Every health care service plan shall include within its disclosure form and within its evidence of coverage a statement clearly describing how participation in the plan may affect the choice of physician, hospital, or other health care providers, the basic method of reimbursement, including the scope and general methods of payment made to its contracting providers of health care services, and whether financial

bonuses or any other incentives are used. The disclosure form and evidence of coverage shall indicate that if an enrollee wishes to know more about these issues, the enrollee may request additional information from the health care service plan, the enrollee's provider, or the provider's medical group or independent practice association regarding the information required pursuant to subdivision (b).

(b) If a plan, medical group, independent practice association, or participating health care provider uses or receives financial bonuses or any other incentives, the plan, medical group, independent practice association, or health care provider shall provide a written summary to any person who requests it that includes all of the following:

(1) A general description of the bonus and any other incentive arrangements used in its compensation agreements. Nothing in this section shall be construed to require disclosure of trade secrets or commercial or financial information that is privileged or confidential, such as payment rates, as determined by the commissioner, pursuant to state law.

(2) A description regarding whether, and in what manner, the bonuses and any other incentives are related to a provider's use of referral services.

(c) The statements and written information provided pursuant to subdivisions (a) and (b) shall be communicated in clear and simple language that enables consumers to evaluate and compare health care service plans.

(d) (1) The plan shall clearly inform prospective enrollees that participation in that plan will affect the person's choice of provider by placing the following statement in a conspicuous place on all material required to be given to prospective enrollees including promotional and descriptive material, disclosure forms, and certificates and evidences of coverage:

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED

It is not the intent of this section to require that the names of individual health care providers be enumerated to prospective enrollees.

If the health care service plan provides a list of providers to patients or contracting providers, the plan shall include within the provider listing a notification that enrollees may contact the plan in order to obtain a list of the facilities with which the health care service plan is contracting for subacute care and/or transitional inpatient care.

(2) The plan shall clearly inform prospective enrollees that the choice of certain hospitals, clinics, ambulatory surgical centers, independent physician associations, medical groups, or pharmacies will affect the person's ability to access comprehensive reproductive health services, as defined in subdivision (c) of Section 1345, by placing the following statement in a conspicuous place on all materials required to be given to prospective enrollees, including promotional and descriptive materials, disclosure forms, and certificates and evidences of coverage.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW WHICH FACILITIES AND GROUPS OF PROVIDERS RESTRICT ACCESS TO COMPREHENSIVE REPRODUCTIVE HEALTH CARE SERVICES

SEC. 13. Section 1367.696 is added to the Health and Safety Code, to read:

1367.696. (a) On and after July 1, 2000, notwithstanding any other provision of law, whenever a health care service plan, except a specialized health care service plan, contracts with a hospital, clinic, ambulatory surgical center, independent physician association,

medical group, pharmacy, or other primary, ancillary, or specialty health care facility or provider that excludes, limits, or restricts the provision of reproductive health services enumerated in subdivision (c) of Section 1345, it shall also contract with and make available and accessible to its enrollees, a similar provider or facility that does not exclude, limit, or restrict the service. These services shall be available and accessible within reasonable proximity to the residence or place of business of the enrollee, except when no such facility exists, in which case, the plan shall provide transportation.

(b) A health care service plan shall provide to all enrollees written notice in readily understood language and in a clearly organized format on how to access comprehensive reproductive health services, as defined in subdivision (c) of Section 1345. This written notice shall be provided, commencing March 1, 2000, upon the enrollee's enrollment, and annually thereafter. In addition, the plan shall provide this written notice to all pregnant enrollees during the course of prenatal care if the plan received notice, whether by receipt of a claim, a request for preauthorization for pregnancy-related services, or other actual notice that the enrollee is pregnant.

SEC. 14. Section 1367.697 is added to the Health and Safety Code, to read:

1367.697. Notwithstanding any other provision of law, every health care service plan contract issued, amended, or renewed on or after July 1, 2000, that covers tubal ligations shall ensure that voluntary tubal ligations are available at the time of labor and delivery, including by providing transportation if necessary to access services. Nothing in this section shall be construed to permit a plan to apply a higher deductible or copayment for services provided under this section.

SEC. 15. Section 129021 is added to the Health and Safety Code, to read:

129021. Notwithstanding any other provision of law, the office shall not approve an application or provide loan insurance under this chapter to any borrower that

discriminates on the basis of race, color, religion, national origin, ancestry, sex, or sexual orientation.

SEC. 16. Section 129050 of the Health and Safety Code is amended to read:

129050. A loan shall be eligible for insurance under this chapter if all of the following conditions are met:

(a) When the borrower is a nonprofit corporation, the loan shall be secured by a mortgage, first lien, trust indenture, or other security agreement that the office may require subject only to those conditions, covenants and restrictions, easements, taxes, and assessments of record approved by the office. When the borrower is a political subdivision, the loan may be evidenced by a duly authorized bond issue. A loan to a local hospital district or county may meet the requirement of this subdivision by either method.

(b) The borrower obtains an American Land Title Association title insurance policy with the office designated as beneficiary, with liability equal to the amount of the loan insured under this chapter, and with additional endorsements that the office may reasonably require.

(c) The proceeds of the loan shall be used exclusively for the construction, improvement, or expansion of the health facility, as approved by the office under Section 129020. However, loans insured pursuant to this chapter may include loans to refinance another prior loan, whether or not state insured and without regard to the date of the prior loan, if the office determines that the prior loan would have been eligible for insurance under this chapter at the time it was made. The office may not insure a loan for a health facility that is not needed as determined by the state plan developed under the authorization of Section 129020.

(d) The loan shall have a maturity date not exceeding 30 years from the date of the beginning of amortization of the loan, except as authorized by subdivision (e), or 75 percent of the office’s estimate of the economic life of the health facility, whichever is the lesser.

(e) The loan shall contain complete amortization provisions requiring periodic payments by the borrower not in excess of its reasonable ability to pay as determined by the office. The office shall permit a reasonable period of time during which the first payment to amortization may be waived on agreement by the lender and borrower. The office may, however, waive the amortization requirements of this subdivision and of subdivision (g) of this section when a term loan would be in the borrower's best interest.

(f) The loan shall bear interest on the amount of the principal obligation outstanding at any time at a rate, as negotiated by the borrower and lender, as the office finds necessary to meet the loan money market. As used in this chapter, ''interest'' does not include premium charges for insurance and service charges if any. Where a loan is evidenced by a bond issue of a political subdivision, the interest thereon may be at any rate the bonds may legally bear.

(g) The loan shall provide for the application of the borrower's periodic payments to amortization of the principal of the loan.

(h) The loan shall contain those terms and provisions with respect to insurance, repairs, alterations, payment of taxes and assessments, foreclosure proceedings, anticipation of maturity, additional and secondary liens, and other matters the office may in its discretion prescribe.

(i) The loan shall have a principal obligation not in excess of an amount equal to 90 percent of the total construction cost. Where the borrower is a political subdivision, the office may fully insure loans equal to the total construction cost.

(j) The borrower shall offer reasonable assurance that the services of the health facility will be made available to all persons residing or employed in the area served by the facility.

(k) A certificate of need or certificate of exemption has been issued for the project to be financed pursuant to

Chapter 1 (commencing with Section 127125) of Part 2, unless the project is not subject to this requirement.

(*l*) In the case of acquisitions, a project loan shall be guaranteed only for transactions not in excess of the fair market value of the acquisition.

Fair market value shall be determined, for purposes of this subdivision, pursuant to the following procedure, that shall be utilized during the state review of a loan guarantee application:

(1) Completion of a property appraisal by an appraisal firm qualified to make appraisals, as determined by the office, before closing a loan on the project.

(2) Evaluation of the appraisal in conjunction with the book value of the acquisition by the office. When acquisitions involve additional construction, the office shall evaluate the proposed construction to determine that the costs are reasonable for the type of construction proposed. In those cases where this procedure reveals that the cost of acquisition exceeds the current value of a facility, including improvements, then the acquisition cost shall be deemed in excess of fair market value.

(m) Notwithstanding subdivision (i), any loan in the amount of five million dollars ($5,000,000) or less may be insured up to 95 percent of the total construction cost.

(n) In determining financial feasibility of projects of counties pursuant to this section, the office shall take into consideration any assistance for the project to be provided under Sections 14085.5 and 16715 of the Welfare and Institutions Code or from other sources. It is the intent of the Legislature that the office endeavor to assist counties in whatever ways are possible to arrange loans that will meet the requirements for insurance prescribed by this section.

(o) (1) Each borrower, notwithstanding any other provision of law, shall give reasonable assurance to the office that the borrower does not discriminate on the basis of race, religion, national origin, ancestry, sex, or sexual orientation.

(2) Each borrower, notwithstanding any other provision of law, that is a general acute care hospital,

special health care facility that delivers general health services, community clinic, or any other facility that provides inpatient or outpatient care, as defined in Section 15432 of the Government Code, shall provide directly, or arrange for the provision of, or jointly provide in conjunction with another licensed facility, those reproductive health services, as defined in subdivision (c) of Section 1345, which the entity is licensed to provide.

SEC. 17. Section 10123.01 is added to the Insurance Code, to read:

10123.01. Notwithstanding any other provision of law, no self-insured employee welfare benefit plan that provides hospital, medical, or surgical expenses shall offer or provide different terms, conditions, or benefits, or place a limitation on coverage under that insurance on the basis of a person's race, color, religion, national origin, ancestry, sex, or sexual orientation.

SEC. 18. Section 10123.12 of the Insurance Code is amended to read:

10123.12. (a) Every disability insurer, including those insurers that contract for alternative rates of payment pursuant to Section 10133, and every self-insured employee welfare benefit plan, which will affect the choice of physician, hospital, or other health care providers shall include within its disclosure form and within its evidence or certificate of coverage a statement clearly describing how participation in the policy or plan may affect the choice of physician, hospital, or other health care providers, and shall clearly inform prospective insureds or plan enrollees that participation in the policy or plan will affect the person's choice in this regard by placing the following statement in a conspicuous place on all material required to be given to prospective insureds or plan enrollees including promotional and descriptive material, disclosure forms, and certificates and evidences of coverage:

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED

It is not the intent of this section to require that the names of individual health care providers be enumerated to prospective enrollees.

If a disability insurer providing coverage for hospital, medical, or surgical expenses provides a list of facilities to patients or contracting providers, the insurer shall include within the provider listing a notification that enrollees may contact the insurer in order to obtain a list of the facilities with which the disability insurer is contracting for subacute care and/or transitional inpatient care.

(b) Every disability insurer, self-insured employee welfare benefit plan, and insurer issuing group or individual policies of disability insurance that covers hospital, medical, or surgical expenses shall clearly inform prospective insureds or plan enrollees that the choice of certain hospitals, clinics, ambulatory surgical centers, independent physician associations, medical groups, or pharmacies will affect the person's ability to access comprehensive reproductive health services, as defined in subdivision (c) of Section 1345 of the Health and Safety Code, by placing the following statement in a conspicuous place on all material required to be given to prospective insureds or plan enrollees, including promotional and descriptive materials, disclosure forms, and certificates and evidences of coverage:

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW WHICH FACILITIES AND GROUPS OF PROVIDERS RESTRICT ACCESS TO COMPREHENSIVE REPRODUCTIVE HEALTH CARE SERVICES

SEC. 19. Section 10123.22 is added to the Insurance Code, immediately following Section 10123.21, to read:

10123.22. (a) On and after July 1, 2000, notwithstanding any other provision of law, whenever a disability insurer or an insurer issuing group or individual policies of disability insurance that provides coverage for hospital, medical, or surgical expenses contracts with a hospital, clinic, medical group, independent physician association, ambulatory surgical center, pharmacy, or other primary, ancillary, or specialty health care facility that excludes, limits, or restricts the provision of reproductive health services enumerated in subdivision (c) of Section 1345 of the Health and Safety Code, it shall also contract with and make available and accessible to its insureds, a similar provider or facility that does not exclude, limit, or restrict the service. These services shall be available and accessible within reasonable proximity to the residence or place of business of the insured, except when no such facility exists, in which case, the insurer shall provide transportation. Nothing in this section shall be construed to permit any insurer to apply a higher deductible or copayment for services provided under this section.

(b) On and after July 1, 2000, notwithstanding any other provision of law, whenever a self-insured employee welfare benefit plan that provides coverage for hospital, medical, or surgical expenses contracts with a hospital, clinic, medical group, independent physician association, ambulatory surgical center, pharmacy, or other primary, ancillary, or specialty health care facility that excludes, limits, or restricts the provision of reproductive health services enumerated in subdivision (c) of Section 1345 of the Health and Safety Code, it shall also contract with and make available and accessible to its enrollees, a similar provider or facility that does not exclude, limit, or restrict the service. These services shall be available and accessible within reasonable proximity to the residence or place of business of the enrollee, except when no such facility exists, in which case, the plan shall provide transportation. Nothing in this section shall be construed to permit any plan to apply a higher deductible or copayment for services provided under this section.

(c) A disability insurer, self-insured employee welfare benefit plan, and insurer issuing group or individual policies of disability insurance that provides coverage for hospital, medical, or surgical expenses shall provide to all insureds or enrollees written notice in readily understood language and in a clearly organized format on how to access comprehensive reproductive health services, as defined in subdivision (c) of Section 1345 of the Health and Safety Code. This written notice shall be provided, commencing March 1, 2000, upon the insured's or enrollee's enrollment, and annually thereafter. In addition, the insurer or plan shall provide this written notice to all pregnant insureds or enrollees during the course of prenatal care if the plan received notice, whether by receipt of a claim, a request for preauthorization for pregnancy-related services, or other actual notice that the insured or enrollee is pregnant.

SEC. 20. Section 10123.89 is added to the Insurance Code, immediately following Section 10123.88, to read:

10123.89. Commencing July 1, 2000, notwithstanding any other provision of law, every disability insurer, self-insured employee welfare benefit plan, and insurer issuing group or individual policies of insurance that covers hospital, medical, or surgical expenses and that covers tubal ligations shall ensure that voluntary tubal ligations are available at the time of labor and delivery. These services shall be available and accessible within reasonable proximity to the residence or place of business of the insured or enrollee, except when no such facility exists, in which case, the insurer or plan shall provide transportation. Nothing in this section shall be construed to permit any insurer or plan to apply a higher deductible or copayment for services provided under this section.

SEC. 21. Section 10140 of the Insurance Code is amended to read:

10140. (a) No admitted insurer, licensed to issue life or disability insurance, shall fail or refuse to accept an application for that insurance, to issue that insurance to an applicant therefor, or issue or cancel that insurance, under conditions less favorable to the insured than in

other comparable cases, except for reasons applicable alike to persons of every race, color, religion, national origin, ancestry, or sexual orientation. Race, color, religion, national origin, ancestry, or sexual orientation shall not, of itself, constitute a condition or risk for which a higher rate, premium, or charge may be required of the insured for that insurance.

(b) Except as otherwise permitted by law, no admitted insurer, licensed to issue disability insurance policies for hospital, medical, and surgical expenses, shall fail or refuse to accept an application for that insurance, fail or refuse to issue that insurance to an applicant therefor, cancel that insurance, refuse to renew that insurance, charge a higher rate or premium for that insurance, or offer or provide different terms, conditions, or benefits, or place a limitation on coverage under that insurance, on the basis of a person's genetic characteristics that may, under some circumstances, be associated with disability in that person or that person's offspring.

(c) No admitted insurer, licensed to issue disability insurance for hospital, medical, and surgical expenses, shall seek information about a person's genetic characteristics for any nontherapeutic purpose.

(d) No discrimination shall be made in the fees or commissions of agents or brokers for writing or renewing a policy of disability insurance, other than disability income, on the basis of a person's genetic characteristics that may, under some circumstances, be associated with disability in that person or that person's offspring.

(e) It shall be deemed a violation of subdivision (a) for any insurer to consider sexual orientation in its underwriting criteria or to utilize marital status, living arrangements, occupation, gender, beneficiary designation, ZIP Codes or other territorial classification within this state, or any combination thereof for the purpose of establishing sexual orientation or determining whether to require a test for the presence of the human immunodeficiency virus or antibodies to that virus, where that testing is otherwise permitted by law. Nothing

in this section shall be construed to alter, expand, or limit in any manner the existing law respecting the authority of insurers to conduct tests for the presence of human immunodeficiency virus or evidence thereof.

(f) This section shall not be construed to limit the authority of the commissioner to adopt regulations prohibiting discrimination because of sex, marital status, or sexual orientation or to enforce these regulations, whether adopted before or on or after January 1, 1991.

(g) ''Genetic characteristics'' as used in this section shall have the same meaning as defined in Section 10123.3.

(h) Notwithstanding any other provision of law, no admitted insurer licensed to issue disability insurance policies for hospital, medical, and surgical expenses shall offer or provide different terms, conditions, or benefits, or place a limitation on coverage under that insurance on the basis of a person's race, color, religion, national origin, ancestry, sex, or sexual orientation.

SEC. 22. Section 10198.71 is added to the Insurance Code, to read:

10198.71. Notwithstanding any other provision of law, no health benefit plan, as defined in subdivision (a) of Section 10198.6, shall offer or provide different terms, conditions, or benefits, or place a limitation on coverage under that insurance on the basis of a person's race, color, religion, national origin, ancestry, sex, or sexual orientation.

SEC. 23. Section 10291.5 of the Insurance Code is amended to read:

10291.5. (a) The purpose of this section is to achieve both of the following:

(1) Prevent, in respect to disability insurance, fraud, unfair trade practices, and insurance economically unsound to the insured.

(2) Assure that the language of all insurance policies can be readily understood and interpreted.

(b) The commissioner shall not approve any disability policy for insurance or delivery in this state in any of the following circumstances:

(1) If the commissioner finds that it contains any provision, or has any label, description of its contents, title, heading, backing, or other indication of its provisions which is unintelligible, uncertain, ambiguous, or abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued.

(2) If it contains any provision for payment at a rate, or in an amount (other than the product of rate times the periods for which payments are promised) for loss caused by particular event or events (as distinguished from character of physical injury or illness of the insured) more than triple the lowest rate, or amount, promised in the policy for the same loss caused by any other event or events (loss caused by sickness, loss caused by accident, and different degrees of disability each being considered, for the purpose of this paragraph, a different loss); or if it contains any provision for payment for any confining loss of time at a rate more than six times the least rate payable for any partial loss of time or more than twice the least rate payable for any nonconfining total loss of time; or if it contains any provision for payment for any nonconfining total loss of time at a rate more than three times the least rate payable for any partial loss of time.

(3) If it contains any provision for payment for disability caused by particular event or events (as distinguished from character of physical injury or illness of the insured) payable for a term more than twice the least term of payment provided by the policy for the same degree of disability caused by any other event or events; or if it contains any benefit for total nonconfining disability payable for lifetime or for more than 12 months and any benefit for partial disability, unless the benefit for partial disability is payable for at least three months; or if it contains any benefit for total confining disability payable for lifetime or for more than 12 months, unless it also contains benefit for total nonconfining disability caused by the same event or events payable for at least three months, and, if it also contains any benefit for partial disability, unless the benefit for partial disability is payable for at least three months. The provisions of this

paragraph shall apply separately to accident benefits and to sickness benefits.

(4) If it contains *any* provision or provisions which would have the effect, upon any termination of the policy, of reducing or ending the liability that the insurer would have, but for the termination, for loss of time resulting from accident occurring while the policy is in force or for loss of time commencing while the policy is in force and resulting from sickness contracted while the policy is in force or for other losses resulting from accident occurring or sickness contracted while the policy is in force, and also contains *any* provision or provisions reserving to the insurer the right to cancel or refuse to renew the policy, unless it also contains other provision or provisions the effect of which is that termination of the policy as the result of the exercise by the insurer of ~~any such right~~ *the right to cancel or refuse to renew the policy* shall not reduce or end the liability in respect to the hereinafter specified losses as the insurer would have had under the policy, including its other limitations, conditions, reductions, and restrictions, had the policy not been so terminated.

The specified losses referred to in the preceding paragraph are:

(i) Loss of time that commences while the policy is in force and results from sickness contracted while the policy is in force.

(ii) Loss of time that commences within 20 days following and results from accident occurring while the policy is in force.

(iii) Losses that result from accident occurring or sickness contracted while the policy is in force and arise out of the care or treatment of illness or injury and which occur within 90 days from the termination of the policy or during a period of continuous compensable loss or losses which period commences prior to the end of ~~such~~ *the* 90 days.

(iv) Losses other than those specified in clause (i), (ii), or (iii) that result from accident occurring or sickness contracted while the policy is in force and which losses

occur within 90 days following the accident or the contraction of the sickness.

(5) If by any caption, label, title, or description of contents the policy states, implies, or infers without reasonable qualification that it provides loss of time indemnity for lifetime, or for any period of more than two years, if the loss of time indemnity is made payable only when house confined or only under special contingencies not applicable to other total loss of time indemnity.

(6) If it contains any benefit for total confining disability payable only upon condition that the confinement be of an abnormally restricted nature unless the caption of the part containing the benefit is accurately descriptive of the nature of the confinement required and unless, if the policy has a description of contents, label, or title, at least one of them contain reference to the nature of the confinement required.

(7) (A) If, irrespective of the premium charged therefor, any benefit of the policy is, or the benefits of the policy as a whole are, not sufficient to be of real economic value to the insured.

(B) In determining whether benefits are of real economic value to the insured, the commissioner shall not differentiate between insureds of the same or similar economic or occupational classes and shall give due consideration to all of the following:

(i) The right of insurers to exercise sound underwriting judgment in the selection and amounts of risks.

(ii) Amount of benefit, length of time of benefit, nature or extent of benefit, or any combination of those factors.

(iii) The relative value in purchasing power of the benefit or benefits.

(iv) Differences in insurance issued on an industrial or other special basis.

(C) To be of real economic value, it shall not be necessary that any benefit or benefits cover the full amount of any loss that might be suffered by reason of the occurrence of any hazard or event insured against.

(8) If it substitutes a specified indemnity upon the occurrence of accidental death for any benefit of the policy, other than a specified indemnity for dismemberment, which would accrue prior to the time of that death or if it contains any provision that has the effect, other than at the election of the insured exercisable within not less than 20 days in the case of benefits specifically limited to the loss by removal of one or more fingers or one or more toes or within not less than 90 days in all other cases, of doing any of the following:

(A) Of substituting, upon the occurrence of the loss of both hands, both feet, one hand and one foot, the sight of both eyes or the sight of one eye and the loss of one hand or one foot, some specified indemnity for any or all benefits under the policy unless the indemnity so specified is equal to or greater than the total of the benefit or benefits for which the specified indemnity is substituted and which, assuming in all cases that the insured would continue to live, could possibly accrue within four years from the date of the dismemberment under all other provisions of the policy applicable to the particular event or events (as distinguished from character of physical injury or illness) causing the dismemberment.

(B) Of substituting, upon the occurrence of any other dismemberment some specified indemnity for any or all benefits under the policy unless the indemnity so specified is equal to or greater than one-fourth of the total of the benefit or benefits for which the specified indemnity is substituted and which, assuming in all cases that the insured would continue to live, could possibly accrue within four years from the date of the dismemberment under all other provisions of the policy applicable to the particular event or events (as distinguished from character of physical injury or illness) causing the dismemberment.

(C) Of substituting a specified indemnity upon the occurrence of any dismemberment for any benefit of the policy which would accrue prior to the time of dismemberment.

As used in this section, loss of a hand shall be severance at or above the wrist joint, loss of a foot shall be severance at or above the ankle joint, loss of an eye shall be the irrecoverable loss of the entire sight thereof, loss of a finger shall mean at least one entire phalanx thereof and loss of a toe, the entire toe.

(9) If it contains provision, other than as provided in Section 10369.3, reducing any original benefit more than 50 percent on account of age of the insured.

(10) If the insuring clause or clauses contain no reference to the exceptions, limitations, and reductions (if any) or no specific reference to, or brief statement of, each abnormally restrictive exception, limitation, or reduction.

(11) If it contains benefit or benefits for loss or losses from specified diseases only unless:

(A) All of the diseases so specified in each provision granting the benefits fall within some general classification based upon the following:

(i) The part or system of the human body principally subject to all of the diseases.

(ii) The similarity in nature or cause of ~~such~~ *the* diseases.

(iii) In case of diseases of an unusually serious nature and protracted course of treatment, the common characteristics of all of the diseases with respect to severity of affliction and cost of treatment.

(B) The policy is entitled and each provision granting the benefits is separately captioned in clearly understandable words so as to accurately describe the classification of diseases covered and expressly point out, when that is the case, that not all diseases of the classification are covered.

(12) If it does not contain provision for a grace period of at least the number of days specified below for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force provided, that the grace period to be included in the policy shall be not less than seven days for policies providing for weekly payment of premium, not

less than 10 days for policies providing for monthly payment of premium and not less than 31 days for all other policies.

(13) If it fails to conform in any respect with any law of this state.

(14) If it discriminates on the basis of race, color, religion, national origin, ancestry, sex, or sexual orientation as prohibited in subdivision (h) of Section 10140.

(c) The commissioner shall not approve any disability policy covering hospital, medical, or surgical expenses unless the commissioner finds that the application conforms to both of the following requirements:

(1) All applications for disability insurance covering hospital, medical, or surgical expenses, except that which is guaranteed issue, which include questions relating to medical conditions, shall contain clear and unambiguous questions designed to ascertain the health condition or history of the applicant.

(2) The application questions designed to ascertain the health condition or history of the applicant shall be based on medical information that is reasonable and necessary for medical underwriting purposes. The application shall include a prominently displayed notice that states:

''California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.''

(d) Nothing in this section authorizes the commissioner to establish or require a single or standard application form for application questions.

(e) The commissioner may, from time to time as conditions warrant, after notice and hearing, promulgate those reasonable rules and regulations, and amendments and additions thereto, as are necessary or convenient, to establish, in advance of the submission of policies, the standard or standards conforming to subdivision (b), by which he or she shall disapprove or withdraw approval of any disability policy.

In promulgating a rule or regulation the commissioner shall give consideration to the criteria herein established and to the desirability of approving for use in policies in this state uniform provisions, nationwide or otherwise, and is hereby granted the authority to consult with insurance authorities of any other state and their representatives individually or by way of convention or committee, to seek agreement upon those provisions.

A rule or regulation shall be promulgated in accordance with the procedure provided in Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(f) The commissioner may withdraw approval of filing of any policy or other document or matter required to be approved by the commissioner, or filed with him or her, by this chapter when the commissioner would be authorized to disapprove or refuse filing of the same if originally submitted at the time of the action of withdrawal.

The withdrawal shall be in writing and shall specify reasons. An insurer adversely affected by ~~any such~~ *the* withdrawal may, within a period of 30 days following mailing or delivery of the writing containing the withdrawal, by written request, secure a hearing to determine whether the withdrawal should be annulled, modified, or confirmed. Unless, at any time, it is mutually agreed to the contrary, a hearing shall be granted and commenced within 30 days following filing of the request and shall proceed with reasonable dispatch to determination. Unless the commissioner in writing in the withdrawal, or subsequent thereto, grants an extension, the withdrawal shall, in the absence of the request, be effective, prospectively and not retroactively, on the 91st day following the mailing or delivery of the withdrawal, and, if request for the hearing is filed, on the 91st day following mailing or delivery of written notice of the commissioner's determination.

(g) No proceeding under this section is subject to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(h) Except as provided in subdivision (k), any action taken by the commissioner under this section is subject to review by the courts of this state and proceedings on review shall be in accordance with the Code of Civil Procedure.

Notwithstanding any other provision of law to the contrary, petition for review may be filed at any time before the effective date of the action taken by the commissioner. No action of the commissioner shall become effective before the expiration of 20 days after written notice and a copy thereof are mailed or delivered to the person adversely affected, and any action so submitted for review shall not become effective for a further period of 15 days after the filing of the petition in court. The court may stay the effectiveness thereof for a longer period.

(i) This section shall be liberally construed to effectuate the purpose and intentions herein stated; but shall not be construed to grant the commissioner power to fix or regulate rates for disability insurance or prescribe a standard form of disability policy, except that the commissioner shall prescribe a standard supplementary disclosure form for presentation with all disability insurance policies, pursuant to Section 10603.

(j) This section shall be effective on and after July 1, 1950, as to all policies thereafter submitted and on and after January 1, 1951, the commissioner may withdraw approval pursuant to subdivision (d) of any policy thereafter issued or delivered in this state irrespective of when its form may have been submitted or approved, and prior to those dates the provisions of law in effect on January 1, 1949, shall apply to those policies.

(k) A policy issued by an insurer to an insured on a form approved by the commissioner, and in accordance with the conditions, if any, contained in the approval, at a time when that approval is outstanding shall, as between the insurer and the insured, or any person claiming under the policy, be conclusively presumed to comply with, and conform to, this section.

SEC. 24. Section 10604 of the Insurance Code is amended to read:

10604. The disclosure form shall include the following information, in concise and specific terms, relative to the disability insurance policy:

(a) The applicable category or categories of coverage provided by the policy, from among the following:

(1) Basic hospital expense coverage.

(2) Basic medical-surgical expense coverage.

(3) Hospital confinement indemnity coverage.

(4) Major medical expense coverage.

(5) Disability income protection coverage.

(6) Accident only coverage.

(7) Specified disease or specified accident coverage.

(8) Any other categories as the commissioner may prescribe.

(b) (1) The principal benefits and coverage of the disability insurance policy.

(2) For insurers issuing group or individual policies of disability insurance that covers hospital, medical, or surgical expenses, the benefits and coverage of comprehensive reproductive health services, as defined in subdivision (c) of Section 1345 of the Health and Safety Code.

(c) (1) The exceptions, reductions, and limitations that apply to the policy.

(2) For insurers issuing group or individual policies of disability insurance that covers hospital, medical, surgical expenses, the exceptions, reductions, and limitations that apply to comprehensive reproductive health services, as defined in subdivision (c) of Section 1345 of the Health and Safety Code.

(d) A summary, including a citation of the relevant contractual provisions, of the process used to authorize or deny payments for services under the coverage provided by the policy including coverage for subacute care, transitional inpatient care, or care provided in skilled nursing facilities. This subdivision shall only apply to policies of disability insurance that cover hospital, medical, or surgical expenses.

(e) The full premium cost of the policy.

(f) Any copayment, coinsurance, or deductible requirements that may be incurred by the insured or his or her family in obtaining coverage under the policy.

(g) The terms under which the policy may be renewed by the insured, including any reservation by the insurer of any right to change premiums.

(h) A statement that the disclosure form is a summary only, and that the policy itself should be consulted to determine governing contractual provisions.

SEC. 25. Section 10702.2 is added to the Insurance Code, to read:

10702.2. Notwithstanding any other provision of law, no person or entity described in Section 10702 shall offer or provide different terms, conditions, or benefits, or place a limitation on coverage, under health benefit plans on the basis of race, color, religion, national origin, ancestry, sex, or sexual orientation.

SEC. 26. Section 10705 of the Insurance Code is amended to read:

10705. Upon the effective date of this act:

(a) No group or individual policy or contract or certificate of group insurance or statement of group coverage providing benefits to employees of small employers as defined in this chapter shall be issued or delivered by a carrier subject to the jurisdiction of the commissioner regardless of the situs of the contract or master policyholder or of the domicile of the carrier nor, except as otherwise provided in Sections 10270.91 and 10270.92, shall a carrier provide coverage subject to this chapter until a copy of the form of the policy, contract, certificate, or statement of coverage is filed with and approved by the commissioner in accordance with Sections 10290 and 10291, and the carrier has complied with the requirements of Section 10717.

(b) Each carrier, except a self-funded employer, shall fairly and affirmatively offer, market, and sell all of the carrier's benefit plan designs that are sold to, offered through, or sponsored by, small employers or associations that include small employers to all small employers in

each geographic region in which the carrier makes coverage available or provides benefits. A carrier contracting to participate in the Voluntary Alliance Uniting Employers Purchasing Program shall be deemed to be in compliance with this requirement for a benefit plan design offered through the program in those geographic regions in which the carrier participates in the program and the benefit plan design is offered exclusively through the program.

(1) Nothing in this section shall be construed to require an association, or a trust established and maintained by an association to receive a master insurance policy issued by an admitted insurer and to administer the benefits thereof solely for association members, to offer, market or sell a benefit plan design to those who are not members of the association. However, if the association markets, offers or sells a benefit plan design to those who are not members of the association it is subject to the requirements of this section. This shall apply to an association that otherwise meets the requirements of paragraph (5) formed by merger of two or more associations after January 1, 1992, if the predecessor organizations had been in active existence on January 1, 1992, and for at least five years prior to that date and met the requirements of paragraph (5).

(2) A carrier which (A) effective January 1, 1992, and at least 20 years prior to that date, markets, offers, or sells benefit plan designs only to all members of one association and (B) does not market, offer or sell any other individual, selected group, or group policy or contract providing medical, hospital and surgical benefits shall not be required to market, offer, or sell to those who are not members of the association. However, if the carrier markets, offers or sells any benefit plan design or any other individual, selected group, or group policy or contract providing medical, hospital and surgical benefits to those who are not members of the association it is subject to the requirements of this section.

(3) Each carrier that sells health benefit plans to members of one association pursuant to paragraph (2)

shall submit an annual statement to the commissioner which states that the carrier is selling health benefit plans pursuant to paragraph (2) and which, for the one association, lists all the information required by paragraph (4).

(4) Each carrier that sells health benefit plans to members of any association shall submit an annual statement to the commissioner which lists each association to which the carrier sells health benefit plans, the industry or profession that is served by the association, the association's membership criteria, a list of officers, the state in which the association is organized, and the site of its principal office.

(5) For purposes of paragraphs (1) and (2), an association is a nonprofit organization comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or small employer meeting its membership criteria, which do not condition membership directly or indirectly on the health or claims history of any person, which uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered by the association, which is organized and maintained in good faith for purposes unrelated to insurance, which has been in active existence on January 1, 1992, and at least five years prior to that date, which has a constitution and bylaws, or other analogous governing documents which provide for election of the governing board of the association by its members, which has contracted with one or more carriers to offer one or more health benefit plans to all individual members and small employer members in this state.

(c) Each carrier shall make available to each small employer all benefit plan designs that the carrier offers or sells to small employers or to associations that include small employers. Notwithstanding subdivision (d) of Section 10700, for purposes of this subdivision, companies

that are affiliated companies or that are eligible to file a consolidated income tax return shall be treated as one carrier.

(d) Each carrier shall do all of the following:

(1) Prepare a brochure that summarizes all of its benefit plan designs and make this summary available to small employers, agents and brokers upon request. The summary shall include for each benefit plan design information on benefits provided, including comprehensive reproductive health services, as defined in subdivision (c) of Section 1345 of the Health and Safety Code, a generic description of the manner in which services are provided, such as how access to providers is limited, benefit limitations, including limits on comprehensive reproductive health services, as defined in subdivision (c) of Section 1345 of the Health and Safety Code, required copayments and deductibles, standard employee risk rates, an explanation of how creditable coverage is calculated if a preexisting condition or affiliation period is imposed, and a telephone number that can be called for more detailed benefit information. Carriers are required to keep the information contained in the brochure accurate and up to date, and, upon updating the brochure, send copies to agents and brokers representing the carrier. Any entity that provides administrative services only with regard to a benefit plan design written or issued by another carrier shall not be required to prepare a summary brochure which includes that benefit plan design.

(2) For each benefit plan design, prepare a more detailed evidence of coverage and make it available to small employers, agents and brokers upon request. The evidence of coverage shall contain all information, including information about comprehensive reproductive health services, as defined in subdivision (c) of Section 1345 of the Health and Safety Code, that a prudent buyer would need to be aware of in making selections of benefit plan designs. An entity that provides administrative services only with regard to a benefit plan design written or issued by another carrier shall not be

required to prepare an evidence of coverage for that benefit plan design.

(3) Provide to small employers, agents, and brokers, upon request, for any given small employer the sum of the standard employee risk rates and the sum of the risk adjusted standard employee risk rates. When requesting this information, small employers, agents and brokers shall provide the carrier with the information the carrier needs to determine the small employer's risk adjusted employee risk rate.

(4) Provide copies of the current summary brochure to all agents or brokers who represent the carrier and, upon updating the brochure, send copies of the updated brochure to agents and brokers representing the carrier for the purpose of selling health benefit plans.

(5) Notwithstanding subdivision (d) of Section 10700, for purposes of this subdivision, companies that are affiliated companies or that are eligible to file a consolidated income tax return shall be treated as one carrier.

(e) Every agent or broker representing one or more carriers for the purpose of selling health benefit plans to small employers shall do all of the following:

(1) When providing information on a health benefit plan to a small employer but making no specific recommendations on particular benefit plan designs:

(A) Advise the small employer of the carrier's obligation to sell to any small employer any of the benefit plan designs it offers to small employers and provide them, upon request, with the actual rates that would be charged to that employer for a given benefit plan design.

(B) Notify the small employer that the agent or broker will procure rate and benefit information for the small employer on any benefit plan design offered by a carrier for whom the agent or broker sells health benefit plans.

(C) Notify the small employer that, upon request, the agent or broker will provide the small employer with the summary brochure required in paragraph (1) of subdivision (d) for any benefit plan design offered by a carrier whom the agent or broker represents.

(2) When recommending a particular benefit plan design or designs, advise the small employer that, upon request, the agent will provide the small employer with the brochure required by paragraph (1) of subdivision (d) containing the benefit plan design or designs being recommended by the agent or broker.

(3) Prior to filing an application for a small employer for a particular health benefit plan:

(A) For each of the benefit plan designs offered by the carrier whose benefit plan design the agent or broker is presenting, provide the small employer with the benefit summary required in paragraph (1) of subdivision (d) and the sum of the standard employee risk rates for that particular employer.

(B) Notify the small employer that, upon request, the agent or broker will provide the small employer with an evidence of coverage brochure for each benefit plan design the carrier offers.

(C) Notify the small employer that, from July 1, 1993 to July 1, 1996, actual rates may be 20 percent higher or lower than the sum of the standard employee risk rates, and from July 1, 1996, and thereafter, actual rates may be 10 percent higher or lower than the sum of the standard employee risk rates depending on how the carrier assesses the risk of the small employer's group.

(D) Notify the small employer that, upon request, the agent or broker will submit information to the carrier to ascertain the small employer's sum of the risk adjusted standard employee risk rate for any benefit plan design the carrier offers.

(E) Obtain a signed statement from the small employer acknowledging that the small employer has received the disclosures required by paragraph (3) of subdivision (e) and by Section 10716.

(f) No carrier, agent, or broker shall induce or otherwise encourage a small employer to separate or otherwise exclude an eligible employee from a health benefit plan which, in the case of an eligible employee meeting the definition in paragraph (1) of subdivision (f) of Section 10700, is provided in connection with the

employee's employment or which, in the case of an eligible employee as defined in paragraph (2) of subdivision (f) of Section 17000, is provided in connection with a guaranteed association.

(g) No carrier shall reject an application from a small employer for a benefit plan design provided:

(1) The small employer as defined by paragraph (1) of subdivision (w) of Section 10700 offers health benefits to 100 percent of its eligible employees as defined in paragraph (1) of subdivision (f) of Section 10700. Employees who waive coverage on the grounds that they have other group coverage shall not be counted as eligible employees.

(2) The small employer agrees to make the required premium payments.

(h) No carrier or agent or broker shall, directly or indirectly, engage in the following activities:

(1) Encourage or direct small employers to refrain from filing an application for coverage with a carrier because of the health status, claims experience, industry, occupation, or geographic location within the carrier's approved service area of the small employer or the small employer's employees.

(2) Encourage or direct small employers to seek coverage from another carrier or the program because of the health status, claims experience, industry, occupation, or geographic location within the carrier's approved service area of the small employer or the small employer's employees.

(i) No carrier shall, directly or indirectly, enter into any contract, agreement, or arrangement with an agent or broker that provides for or results in the compensation paid to an agent or broker for a health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer or the small employer's employees. This subdivision shall not apply with respect to a compensation arrangement that provides compensation to an agent or broker on the basis of percentage of premium, provided that the percentage shall not vary because of the health

status, claims experience, industry, occupation, or geographic area of the small employer.

(j) Except in the case of a late insured, or for satisfaction of a preexisting condition clause in the case of initial coverage of an eligible employee, a disability insurer may not exclude any eligible employee or dependent who would otherwise be entitled to health care services on the basis of any of the following: the health status, the medical condition, including both physical and mental illnesses, the claims experience, the medical history, the genetic information, or the disability or evidence of insurability, including conditions arising out of acts of domestic violence of that employee or dependent. No health benefit plan may limit or exclude coverage for a specific eligible employee or dependent by type of illness, treatment, medical condition, or accident, except for preexisting conditions as permitted by Section 10198.7 or 10708.

(k) If a carrier enters into a contract, agreement, or other arrangement with a third-party administrator or other entity to provide administrative, marketing, or other services related to the offering of health benefit plans to small employers in this state, the third-party administrator shall be subject to this chapter.

(*l*) (1) With respect to the obligation to provide coverage newly issued under subdivision (d), the carrier may cease enrolling new small employer groups and new eligible employees as defined by paragraph (2) of subdivision (f) of Section 10700 if it certifies to the commissioner that the number of eligible employees and dependents, of the employers newly enrolled or insured during the current calendar year by the carrier equals or exceeds: (A) in the case of a carrier that administers any self-funded health benefits arrangement in California, 10 percent of the total number of eligible employees, or eligible employees and dependents, respectively, enrolled or insured in California by that carrier as of December 31 of the preceding year, or (B) in the case of a carrier that does not administer any self-funded health benefit arrangements in California, 8 percent of the total

number of eligible employees, or eligible employees and dependents, respectively, enrolled or insured by the carrier in California as of December 31 of the preceding year.

(2) Certification shall be deemed approved if not disapproved within 45 days after submission to the commissioner. If that certification is approved, the small employer carrier shall not offer coverage to any small employers under any health benefit plans during the remainder of the current year. If the certification is not approved, the carrier shall continue to issue coverage as required by subdivision (d) and be subject to administrative penalties as established in Section 10718.

SEC. 27. Section 14016.5 of the Welfare and Institutions Code is amended to read:

14016.5. (a) (1) At the time of determining or redetermining the eligibility of a Medi-Cal or aid to families with dependent children (AFDC) applicant or beneficiary who resides in an area served by a managed health care plan or pilot program in which beneficiaries may enroll, each applicant or beneficiary shall personally attend a presentation at which the applicant or beneficiary is informed of the managed care and fee-for-service options available regarding methods of receiving Medi-Cal benefits. The county shall ensure that each beneficiary or applicant attends this presentation.

(2) At the time of the presentation and at least 30 days prior to enrollment, the following information shall be provided in writing in readily understood language and in a clearly organized format to each applicant or beneficiary:

(A) The principal benefits and coverage of the plan, including coverage for comprehensive reproductive health services, as defined in subdivision (c) of Section 1345 of the Health and Safety Code, and how to access out-of-plan family planning services.

(B) The hospitals, clinics, ambulatory surgical centers, independent physician associations, medical groups, pharmacies, and other principal primary, ancillary, or

specialty health care facilities available in the health plan network.

(C) The exceptions, reductions, and limitations that apply to the plan, including exceptions, reductions, and limitations on comprehensive reproductive health services, as defined in subdivision (c) of Section 1345 of the Health and Safety Code.

(D) The hospitals, clinics, ambulatory surgical centers, independent physician associations, medical groups, pharmacies, and other primary, ancillary, or specialty health care facilities that do not provide comprehensive reproductive health services, as defined in subdivision (c) of Section 1345 of the Health and Safety Code.

(b) The health care options presentation described in subdivision (a) shall include all of the following elements:

(1) Each beneficiary or eligible applicant shall be informed that he or she may choose to continue an established patient-provider relationship in the fee-for-service sector.

(2) Each beneficiary or eligible applicant shall be provided with the name, address, telephone number, and specialty, if any, of each primary care provider, and each clinic participating in each prepaid managed health care plan, pilot project, or fee-for-service case management provider option. This information shall be provided under geographic area designations, in alphabetical order by the name of the primary care provider and clinic. The name, address, and telephone number of each specialist participating in each prepaid managed care health plan, pilot project, or fee-for-service case management provider option shall be made available by either contacting the health care options contractor or the prepaid managed care health plan, pilot project, or fee-for-service case management provider.

(3) Each beneficiary or eligible applicant shall be informed that he or she may choose to continue an established patient-provider relationship in a managed care option, if his or her treating provider is a primary care provider or clinic contracting with any of the prepaid managed health care plans, pilot projects, or

fee-for-service case management provider options available, has available capacity, and agrees to continue to treat that beneficiary or applicant.

(4) In areas specified by the director, each beneficiary or eligible applicant shall be informed that if he or she fails to make a choice, or does not certify that he or she has an established relationship with a primary care provider or clinic, he or she shall be assigned to, and enrolled in, a prepaid managed health care plan, pilot projects, or fee-for-service case management provider.

(c) No later than 30 days following the date a Medi-Cal or AFDC beneficiary or applicant is determined eligible, the beneficiary or applicant shall indicate his or her choice in writing, as a condition of coverage for Medi-Cal benefits, of either of the following health care options:

(1) To obtain benefits by receiving a Medi-Cal card, which may be used to obtain services from individual providers, that the beneficiary would locate, who choose to provide services to Medi-Cal beneficiaries.

The department may require each beneficiary or eligible applicant, as a condition for electing this option, to sign a statement certifying that he or she has an established patient-provider relationship, or in the case of a dependent, the parent or guardian shall make that certification. This certification shall not require the acknowledgment or guarantee of acceptance, by any indicated Medi-Cal provider or health facility, of any beneficiary making a certification under this section.

(2) (A) To obtain benefits by enrolling in a prepaid managed health care plan, pilot program, or fee-for-service case management provider that has agreed to make Medi-Cal services readily available to enrolled Medi-Cal beneficiaries.

(B) At the time the beneficiary or eligible applicant selects a prepaid managed health care plan, pilot project, or fee-for-service case management provider, the department shall, when applicable, encourage the beneficiary or eligible applicant to also indicate, in writing, his or her choice of primary care provider or clinic contracting with the selected prepaid managed

health care plan, pilot project, or fee-for-service case management provider.

(d) (1) In areas specified by the director, a Medi-Cal or AFDC beneficiary or eligible applicant who does not make a choice, or who does not certify that he or she has an established relationship with a primary care provider or clinic shall be assigned to and enrolled in an appropriate Medi-Cal managed care plan, pilot project, or fee-for-service case management provider providing service within the area in which the beneficiary resides.

(2) If it is not possible to enroll the beneficiary under a Medi-Cal managed care plan or pilot project or a fee-for-service case management provider because of a lack of capacity or availability of participating contractors, the beneficiary shall be provided with a Medi-Cal card and informed about fee-for-service primary care providers who do all of the following:

(A) The providers agree to accept Medi-Cal patients.

(B) The providers provide information about the provider's willingness to accept Medi-Cal patients as described in Section 14016.6.

(C) The providers provide services within the area in which the beneficiary resides.

(e) If a beneficiary or eligible applicant does not choose a primary care provider or clinic or does not select any primary care provider who is available, the managed health care plan, pilot project, or fee-for-service case management provider that was selected by or assigned to the beneficiary shall ensure that the beneficiary selects a primary care provider or clinic within 30 days after enrollment or is assigned to a primary care provider within 40 days after enrollment.

(f) (1) The managed care plan shall have a valid Medi-Cal contract, adequate capacity, and appropriate staffing to provide health care services to the beneficiary.

(2) The department shall establish standards for all of the following:

(A) The maximum distances a beneficiary is required to travel to obtain primary care services from the managed care plan, fee-for-service managed care

provider, or pilot project in which the beneficiary is enrolled.

(B) The conditions under which a primary care service site shall be accessible by public transportation.

(C) The conditions under which a managed care plan, fee-for-service managed care provider, or pilot project shall provide nonmedical transportation to a primary care service site.

(3) In developing the standards required by paragraph (2), the department shall take into account, on a geographic basis, the means of transportation used and distances typically traveled by Medi-Cal beneficiaries to obtain fee-for-service primary care services and the experience of managed care plans in delivering services to Medi-Cal enrollees. The department shall also consider the provider's ability to render culturally and linguistically appropriate services.

(g) To the extent possible, the arrangements for carrying out subdivision (d) shall provide for the equitable distribution of Medi-Cal beneficiaries among participating managed care plans, fee-for-service case management providers, and pilot projects.

(h) If, under the provisions of subdivision (d), a Medi-Cal beneficiary or applicant does not make a choice or does not certify that he or she has an established relationship with a primary care provider or clinic, the person may, at the option of the department, be provided with a Medi-Cal card or be assigned to and enrolled in a managed care plan providing service within the area in which the beneficiary resides.

(i) Any Medi-Cal or AFDC beneficiary who is dissatisfied with the provider or managed care plan, pilot project, or fee-for-service case management provider shall be allowed to select or be assigned to another provider or managed care plan, pilot project, or fee-for-service case management provider.

(j) The department or its contractor shall notify a managed care plan, pilot project, or fee-for-service case management provider when it has been selected by or assigned to a beneficiary. The managed care plan, pilot

project, or fee-for-service case management provider that has been selected by, or assigned to, a beneficiary, shall notify the primary care provider or clinic than it has been selected or assigned. The managed care plan, pilot project, or fee-for-service case management provider shall also notify the beneficiary of the managed care plan, pilot project, or fee-for-service case management provider or clinic selected or assigned.

(k) (1) The department shall ensure that Medi-Cal beneficiaries eligible under Title XVI of the Social Security Act are provided with information about options available regarding methods of receiving Medi-Cal benefits as described in subdivision (c).

(2) (A) The director may waive the requirements of subdivisions (c) and (d) until a means is established to directly provide the presentation described in subdivision (a) to beneficiaries who are eligible for the federal Supplemental Security Income for the Aged, Blind, and Disabled Program (Subchapter 16 (commencing with Section 1381) of Chapter 7 of Title 42 of the United States Code).

(B) The director may elect not to apply the requirements of subdivisions (c) and (d) to beneficiaries whose eligibility under the Supplemental Security Income program is established before January 1, 1994.

(*l*) In areas where there is no prepaid managed health care plan or pilot program which has contracted with the department to provide services to Medi-Cal beneficiaries, and where no other enrollment requirements have been established by the department, no explicit choice need be made, and the beneficiary or eligible applicant shall receive a Medi-Cal card.

(m) The following definitions contained in this subdivision shall control the construction of this section, unless the context requires otherwise:

(1) ''Applicant,'' ''beneficiary,'' or ''eligible applicant,'' in the case of a family group, means any person with legal authority to make a choice on behalf of dependent family members.

(2) ‘‘Fee-for-service case management provider’’ means a provider enrolled and certified to participate in the Medi-Cal fee-for-service case management program the department may elect to develop in selected areas of the state with the assistance of and in cooperation with California physician providers and other interested provider groups.

(3) ‘‘Managed health care plan’’ or ‘‘managed care plan’’ means a person or entity operating under a Medi-Cal contract with the department under this chapter or Chapter 8 (commencing with Section 14200) to provide, or arrange for, health care services for Medi-Cal beneficiaries as an alternative to the Medi-Cal fee-for-service program that has a contractual responsibility to manage health care provided to Medi-Cal beneficiaries covered by the contract.

(n) (1) Whenever a county welfare department notifies a public assistance recipient or Medi-Cal beneficiary that the recipient or beneficiary is losing Medi-Cal eligibility, the county shall include, in the notice to the recipient or beneficiary, notification that the loss of eligibility shall also result in the recipient’s or beneficiary’s disenrollment from Medi-Cal managed care health or dental plans, if enrolled.

(2) (A) Whenever the department or the county welfare department processes a change in a public assistance recipient’s or Medi-Cal beneficiary’s residence or aid code that will result in the recipient’s or beneficiary’s disenrollment from the managed care health or dental plan in which they are currently enrolled, a written notice shall be given to the recipient or beneficiary.

(B) This paragraph shall become operative and the department shall commence sending the notices required under this paragraph on or before the expiration of 12 months after the effective date of this section.

(o) This section shall be implemented in a manner consistent with any federal waiver required to be obtained by the department in order to implement this section.

SEC. 28. Section 14016.71 is added to the Welfare and Institutions Code, to read:

14016.71. (a) On and after July 1, 2000, notwithstanding any other provision of law, whenever a Medi-Cal managed health care plan contracts with a hospital, clinic, ambulatory surgical center, independent physician association, medical group, pharmacy, or other primary, ancillary, or specialty health care facility that excludes, limits, or restricts the provision of reproductive health services enumerated in subdivision (c) of Section 1345 of the Health and Safety Code, it shall also contract with and make available and accessible to its enrollees, a similar provider or facility that does not exclude, limit, or restrict the service. These services shall be available and accessible within reasonable proximity to the residence or place of business of the enrollee, except when no such facility exists, in which case, the plan shall provide transportation. Nothing in this section shall be construed to permit any plan to apply a higher deductible or copayment for services provided under this section.

(b) On and after July 1, 2000, each Medi-Cal managed health care plan shall ensure that voluntary tubal ligations are available at the time of labor and delivery, including by providing transportation if necessary to access services. Nothing in this section shall be construed to permit a Medi-Cal managed health care plan to apply any deductible or copayment for services provided under this section.

(c) For the purposes of this section, ‘‘managed health care plans’’ mean a person or entity including, but not limited to, county organized health systems, pilot projects, primary care case management plans, fee-for-service managed care plans, prepaid health plans, and prepaid health plans that are contracting with, or governed, owned, or operated by, either a county board of supervisors or a county special commission, or a county health authority, operating under a Medi-Cal contract under this chapter or Chapter 8 (commencing with Section 14200), or Chapter 3 (commencing with Section 101675) of Part 4 of Division 101 of the Health and Safety

Code, to provide, arrange, or reimburse for, health services for Medi-Cal beneficiaries as an alternative to the Medi-Cal fee-for-service program that has a contractual responsibility to manage health care provided to Medi-Cal beneficiaries covered by the contract.

(d) A Medi-Cal managed health care plan shall provide to all enrollees and subscribers written notice in readily understood language and in a clearly organized format on how to access comprehensive reproductive health services, as defined in subdivision (c) of Section 1345 of the Health and Safety Code. This written notice shall be provided, commencing March 1, 2000, upon the enrollee's enrollment, and annually thereafter. In addition, the plan shall provide this written notice to all pregnant enrollees during the course of prenatal care if the plan received notice, whether by receipt of a claim, a request for preauthorization for pregnancy-related services, or other actual notice that the enrollee is pregnant.

SEC. 29. Section 14016.8 is added to the Welfare and Institutions Code, to read:

14016.8. (a) Notwithstanding any other provision of law, a managed health care plan shall not discriminate against Medi-Cal beneficiaries and enrollees in the terms, conditions, or benefits and shall prohibit any limitation on coverage or the provision of services on the basis of race, color, religion, national origin, ancestry, sex, or sexual orientation.

(b) For the purposes of this section, ''managed health care plans'' mean a person or entity including, but not limited to, county organized health systems, pilot projects, primary care case management plans, fee-for-service managed care plans, prepaid health plans, and prepaid health plans that are contracting with, or governed, owned, or operated by, either a county board of supervisors or a county special commission, or a county health authority, operating under a Medi-Cal contract under this chapter or Chapter 8 (commencing with Section 14200), or Chapter 3 (commencing with Section 101675) of Part 4 of Division 101 of the Health and Safety

Code, to provide, arrange, or reimburse for, health services for Medi-Cal beneficiaries as an alternative to the Medi-Cal fee-for-service program that has a contractual responsibility to manage health care provided to Medi-Cal beneficiaries covered by the contract.

SEC. 30. Section 14016.9 is added to the Welfare and Institutions Code, to read:

14016.9. (a) All county organized health systems shall provide in writing in readily understood language and in a clearly organized format to each Medi-Cal beneficiary the following information.

(1) The principal benefits and coverage of the managed care plan, including coverage for comprehensive reproductive health services, as defined in subdivision (c) of Section 1345 of the Health and Safety Code, and how to access out-of-plan family planning services.

(2) The hospitals, clinics, ambulatory surgical centers, independent physician associations, medical groups, pharmacies, and other principal primary, ancillary, or specialty health care facilities available in the health plan network.

(3) The exceptions, reductions, and limitations that apply to the plan, including exceptions, reductions, and limitations on comprehensive reproductive health services, as defined in subdivision (c) of Section 1345 of the Health and Safety Code.

(4) The hospitals, clinics, ambulatory surgical centers, independent physician associations, medical groups, pharmacies, and other primary, ancillary, or specialty health care facilities that do not provide comprehensive reproductive health services, as defined in subdivision (c) of Section 1345 of the Health and Safety Code.

(b) This information shall be provided within seven days after a beneficiary has been determined eligible for Medi-Cal to allow beneficiaries to be fully informed prior to making their choice of providers within the county organized health system. Each beneficiary shall have 30 days from the time the information is provided to choose a primary care provider.

(c) For purposes of this section, ‘‘county organized health systems’’ mean a person or entity that is contracting with, or governed, owned, or operated by, either a county board of supervisors or a county special commission, or a county health authority, operating under Article 2.8 (commencing with Section 14087.51) of this chapter or Article 7 (commencing with Section 14490) of Chapter 8, or Chapter 3 (commencing with Section 101675) of Part 4 of Division 101 of the Health and Safety Code, to provide, arrange, or reimburse for, health services for Medi-Cal beneficiaries as an alternative to the Medi-Cal fee-for-service program that has a contractual responsibility to manage health care provided to Medi-Cal beneficiaries covered by the contract.

SEC. 31. Section 14087.305 of the Welfare and Institutions Code is amended to read:

14087.305. (a) In areas specified by the director for expansion of the Medi-Cal managed care program under Section 14087.3 and where the department is contracting with a prepaid health plan that is contracting with, governed, owned or operated by a county board of supervisors, a county special commission or county health authority authorized by Sections 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, and 14087.96, a Medi-Cal or Aid to Families with Dependent Children (AFDC) applicant or beneficiary shall be informed of the managed care options available regarding methods of receiving Medi-Cal benefits. The county shall ensure that each beneficiary is informed of these options and informed that a health care options presentation is available.

(b) The managed care options information described in subdivision (a) shall be provided in writing in readily understood language and in a clearly organized format to each applicant or beneficiary and shall include the following elements:

(1) Each beneficiary or eligible applicant shall be provided with the name, address, telephone number, and specialty, if any, of each primary care provider, by specialty, or clinic, participating in each prepaid health

plan option. This information shall be presented under geographic area designations, in alphabetical order by the name of the primary care provider and clinic. The name, address, and telephone number of each specialist participating in each prepaid health plan shall be made available by contacting the health care options contractor or the prepaid health plan.

(2) Each beneficiary or eligible applicant shall be informed that he or she may choose to continue an established patient-provider relationship in a managed care option, if his or her treating provider is a primary care provider or clinic contracting with any of the prepaid health plan options available and has available capacity and agrees to continue to treat that beneficiary or applicant.

(3) Each beneficiary or eligible applicant shall be informed that if he or she fails to make a choice, he or she shall be assigned to, and enrolled in, a prepaid health plan.

(4) (A) The principal benefits and coverage of the plan, including coverage for comprehensive reproductive health services, as defined in subdivision (c) of Section 1345 of the Health and Safety Code, and how to access out-of-plan family planning services.

(B) The hospitals, clinics, ambulatory surgical centers, independent physician associations, medical groups, pharmacies, and other principal primary, ancillary, or specialty health care facilities available in the health plan network.

(C) The exceptions, reductions, and limitations that apply to the plan, including exceptions, reductions, and limitations on comprehensive reproductive health services, as defined in subdivision (c) of Section 1345 of the Health and Safety Code.

(D) The hospitals, clinics, ambulatory surgical centers, independent physician associations, medical groups, pharmacies, and other primary, ancillary, or specialty health care facilities that do not provide comprehensive reproductive health services, as defined in subdivision (c) of Section 1345 of the Health and Safety Code.

(c) No later than 30 days following the date a Medi-Cal or AFDC beneficiary or applicant is determined eligible for Medi-Cal, the beneficiary shall indicate his or her choice, in writing, from among the available prepaid health plans in the region and his or her choice of primary care provider or clinic contracting with the selected prepaid health plan.

(d) At the time the beneficiary or eligible applicant selects a prepaid health plan, the department shall, when applicable, encourage the beneficiary or eligible applicant to also indicate, in writing, his or her choice of primary care provider or clinic contracting with the selected prepaid health plan.

(e) In areas specified by the director for expansion of the Medi-Cal managed care program under Section 14087.3, and where the department is contracting with a prepaid health plan that is contracting with, governed, owned or operated by a county board of supervisors, a county special commission or county health authority authorized by Sections 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, and 14087.96, a Medi-Cal or AFDC beneficiary who does not make a choice of managed care plans, shall be assigned to and enrolled in an appropriate Medi-Cal prepaid health plan providing service within the area in which the beneficiary resides.

(f) If a beneficiary or eligible applicant does not choose a primary care provider or clinic, or does not select any primary care provider who is available, the prepaid health plan that was selected by or assigned to the beneficiary shall ensure that the beneficiary selects a primary care provider or clinic within 30 days after enrollment or is assigned to a primary care provider within 40 days after enrollment.

(g) Any Medi-Cal or AFDC beneficiary dissatisfied with the primary care provider or prepaid health plan shall be allowed to select or be assigned to another primary care provider within the same prepaid health plan. In addition, the beneficiary shall be allowed to select or be assigned to another prepaid health plan contracted for pursuant to this article that is in effect for the

geographic area in which he or she resides, in accordance with Section 1903 (m) (2) (F) (ii) of the Social Security Act.

(h) The department or its contractor shall notify a prepaid health plan when it has been selected by or assigned to a beneficiary. The prepaid health plan that has been selected by or assigned to a beneficiary shall notify the primary care provider that has been selected or assigned. The prepaid health plan shall also notify the beneficiary of the prepaid health plan and primary care provider or clinic selected or assigned.

(i) (1) The managed health care plan shall have a valid Medi-Cal contract, adequate capacity, and appropriate staffing to provide health care services to the beneficiary.

(2) The department shall establish standards for all of the following:

(A) The maximum distances a beneficiary is required to travel to obtain primary care services from the managed care plan, in which the beneficiary is enrolled.

(B) The conditions under which a primary care service site shall be accessible by public transportation.

(C) The conditions under which a managed care plan shall provide nonmedical transportation to a primary care service site.

(3) In developing the standards required by paragraph (2) the department shall take into account, on a geographic basis, the means of transportation used and distances typically traveled by Medi-Cal beneficiaries to obtain fee-for-service primary care services and the experience of managed care plans in delivering services to Medi-Cal enrollees. The department shall also consider the provider's ability to render culturally and linguistically appropriate services.

(j) To the extent possible, the arrangements for carrying out subdivision (e) shall provide for the equitable distribution of Medi-Cal beneficiaries among participating prepaid health plans, or managed care plans.

(k) This section shall be implemented in a manner consistent with any federal waiver required to be obtained by the department in order to implement this section.

SEC. 32. Section 14089 of the Welfare and Institutions Code is amended to read:

14089. (a) The purpose of this article is to provide a comprehensive program of managed health care plan services to Medi-Cal recipients residing in clearly defined geographical areas. It is, further, the purpose of this article to create maximum accessibility to health care services by permitting Medi-Cal recipients the option of choosing from among two or more managed health care plans or fee-for-service managed case arrangements, including, but not limited to, health maintenance organizations, prepaid health plans, primary care case management plans. Independent practice associations, health insurance carriers, private foundations, and university medical centers systems, not-for-profit clinics, and other primary care providers, may be offered as choices to Medi-Cal recipients under this article if they are organized and operated as managed care plans, for the provision of preventive managed health care plan services.

(b) The negotiator may seek proposals and then shall contract based on relative costs, extent of coverage offered, quality of health services to be provided, financial stability of the health care plan or carrier, recipient access to services, cost-containment strategies, peer and community participation in quality control, emphasis on preventive and managed health care services and the ability of the health plan to meet all requirements for both of the following:

(1) Certification, where legally required, by the Commissioner of Corporations and the Insurance Commissioner.

(2) Compliance with all of the following:

(A) The health plan shall satisfy all applicable state and federal legal requirements for participation as a Medi-Cal managed care contractor.

(B) The health plan shall meet any standards established by the department for the implementation of this article.

(C) The health plan receives the approval of the department to participate in the pilot project under this article.

(c) (1) (A) The proposals shall be for the provision of preventive and managed health care services to specified eligible populations on a capitated, prepaid or postpayment basis.

(B) Enrollment in a Medi-Cal managed health care plan under this article shall be voluntary for beneficiaries eligible for the federal Supplemental Security Income for the Aged, Blind, and Disabled Program (Subchapter 16 (commencing with Section 1381) of Chapter 7 of Title 42 of the United States Code).

(2) The cost of each program established under this section shall not exceed the total amount which the department estimates it would pay for all services and requirements within the same geographic area under the fee-for-service Medi-Cal program.

(d) The department shall enter into contracts pursuant to this article, and shall be bound by the rates, terms, and conditions negotiated by the negotiator.

(e) (1) An eligible beneficiary shall be entitled to enroll in any health care plan contracted for pursuant to this article that is in effect for the geographic area in which he or she resides. Enrollment shall be for a minimum of six months. Contracts entered into pursuant to this article shall be for at least one but no more than three years. The director shall make available to recipients information summarizing the benefits and limitations of each health care plan available pursuant to this section in the geographic area in which the recipient resides.

(2) No later than 30 days following the date a Medi-Cal or AFDC recipient is informed of the health care options described in paragraph (1) of subdivision (e), the recipient shall indicate his or her choice in writing of one of the available health care plans and his or her choice of

primary care provider or clinic contracting with the selected health care plan.

(3) The health care options information described in paragraph (1) of subdivision (e) shall be provided in writing in readily understood language and in a clearly organized format to each applicant or beneficiary and shall include the following elements:

(A) Each beneficiary or eligible applicant shall be provided with the name, address, telephone number, and specialty, if any, of each primary care provider, and each clinic participating in each health care plan. This information shall be presented under geographic area designations in alphabetical order by the name of the primary care provider and clinic. The name, address, and telephone number of each specialist participating in each health care plan shall be made available by contacting the health care options contractor or the health care plan.

(B) Each beneficiary or eligible applicant shall be informed that he or she may choose to continue an established patient-provider relationship in a managed care option, if his or her treating provider is a primary care provider or clinic contracting with any of the health plans available and has the available capacity and agrees to continue to treat that beneficiary or eligible applicant.

(C) Each beneficiary or eligible applicant shall be informed that if he or she fails to make a choice, he or she shall be assigned to, and enrolled in, a health care plan.

(D) (i) The principal benefits and coverage of the plan, including coverage for comprehensive reproductive health services, as defined in subdivision (c) of Section 1345 of the Health and Safety Code, and how to access out-of-plan family planning services.

(ii) The hospitals, clinics, ambulatory surgical centers, independent physician associations, medical groups, pharmacies, and other principal primary, ancillary, or specialty health care facilities available in the health plan network.

(iii) The exceptions, reductions, and limitations that apply to the plan, including exceptions, reductions, and limitations on comprehensive reproductive health

services, as defined in subdivision (c) of Section 1345 of the Health and Safety Code.

(iv) The hospitals, clinics, ambulatory surgical centers, independent physician associations, medical groups, pharmacies, and other primary, ancillary, or specialty health care facilities that do not provide comprehensive reproductive health services, as defined in subdivision (c) of Section 1345 of the Health and Safety Code.

(4) At the time the beneficiary or eligible applicant selects a health care plan, the department shall, when applicable, encourage the beneficiary or eligible applicant to also indicate, in writing, his or her choice of primary care provider or clinic contracting with the selected health care plan.

(5) Commencing with the implementation of a geographic managed care project in a designated county, a Medi-Cal or AFDC beneficiary who does not make a choice of health care plans in accordance with paragraph (2), shall be assigned to and enrolled in an appropriate health care plan providing service within the area in which the beneficiary resides.

(6) If a beneficiary or eligible applicant does not choose a primary care provider or clinic, or does not select any primary care provider who is available, the health care plan selected by or assigned to the beneficiary shall ensure that the beneficiary selects a primary care provider or clinic within 30 days after enrollment or is assigned to a primary care provider within 40 days after enrollment.

(7) Any Medi-Cal or AFDC beneficiary dissatisfied with the primary care provider or health care plan shall be allowed to select or be assigned to another primary care provider within the same health care plan. In addition, the beneficiary shall be allowed to select or be assigned to another health care plan contracted for pursuant to this article that is in effect for the geographic area in which he or she resides in accordance with Section 1903(m)(2)(F)(ii) of the Social Security Act.

(8) The department or its contractor shall notify a health care plan when it has been selected by or assigned

to a beneficiary. The health care plan that has been selected or assigned by a beneficiary shall notify the primary care provider that has been selected or assigned. The health care plan shall also notify the beneficiary of the health care plan and primary care provider selected or assigned.

(9) This section shall be implemented in a manner consistent with any federal waiver that is required to be obtained by the department to implement this section.

(f) A participating county may include within the plan or plans providing coverage pursuant to this section, employees of county government, and others who reside in the geographic area and who depend upon county funds for all or part of their health care costs.

(g) The negotiator and the department shall establish pilot projects to test the cost effectiveness of delivering benefits as defined in subdivisions (a) to (f), inclusive.

(h) The California Medical Assistance Commission shall evaluate the cost effectiveness of these pilot projects after one year of implementation. Pursuant to this evaluation the commission may either terminate or retain the existing pilot projects.

(i) Funds may be provided to prospective contractors to assist in the design, development, and installation of appropriate programs. The award of these funds shall be based on criteria established by the department.

(j) In implementing this article, the department may enter into contracts for the provision of essential administrative and other services. Contracts entered into under this subdivision may be on a noncompetitive bid basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

SEC. 33. Section 14165.6 of the Welfare and Institutions Code is amended to read:

14165.6. The commission shall direct the planning, development and negotiation of contract services which provide for:

(a) The provision of services through a capitation methodology, including, but not limited to, health

maintenance organizations, organized county health systems, insurance companies, and independent practice associations.

(b) Hospital inpatient or hospital outpatient services.

(c) Pilot projects meeting the provisions of Section 14491.5.

(d) Health care projects meeting the provisions of Article 2.91 (commencing with Section 14089).

(e) Notwithstanding any other provision of law, all contracts negotiated by the commission shall prohibit both of the following:

(1) Discrimination against Medi-Cal beneficiaries and enrollees in the terms, conditions, or benefits.

(2) Any limitation on coverage or the provision of services on the basis of race, color, religion, national origin, ancestry, sex, or sexual orientation.

SEC. 34. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution for certain costs that may be incurred by a local agency or school district because in that regard this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

However, notwithstanding Section 17610 of the Government Code, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code. If the statewide cost of the claim for reimbursement does not exceed one million dollars ($1,000,000), reimbursement shall be made from the State Mandates Claims Fund.

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